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THE UNIVERSITY OF ALBERTA

A DESCRIPTION OF EXCEPTIONALLY COMPETENT NURSING PRACTICE

by

BETH ANNE PERRY ©

A THESIS SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF DOCTOR OF PHILOSOPHY IN
EDUCATIONAL ADMINISTRATION

EDMONTON, ALBERTA
FALL 1994

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ABSTRACT

The focus of this study is an exploration of the nature of exceptionally competent nursing practice. Through a combination of data gathering approaches - conversation, observation, and narrative exchange - the beliefs, actions and interactions, and effects of the actions and interactions of eight exceptionally competent nurse informants are studied.

A combination of hermeneutic phenomenology and grounded theory approaches to data analysis is used. Grounded theory guides the conceptual analysis while hermeneutic phenomenology furnishes the descriptive elements. In other words, grounded theory draws the lines for the picture of exceptional nursing practice, hermeneutic analysis gives the picture color.

The nursing philosophies of the study participants are compared and contrasted to those proposed by major nurse theorists. This comparison reveals that the exceptional nurses have well developed beliefs about the nature of nursing, the nursing milieu, health, the nature of human-beings, the nature of nurse patient relationships, the importance of self awareness, and life and death. These beliefs go beyond those put forward by the nurse theorists reviewed. The focus of the exceptional nurse informants on genuineness, honesty, and continued learning is also exposed in this discussion.

Further analysis reveals three themes related to the actions and interactions of the exceptionally competent nurses: "dialogue of silence," "mutual touch," and "sharing the lighter side of life." The reciprocal nature of each of these is their primary commonality. These actions and interactions are not done to the other, they are shared experiences, done with another.

Additional analysis leads to a category called effects of nursing actions and interactions. Three themes are highlighted as effects: "affirmation of value of the nurse and patient," "connecting," and "joint transcendence." Of these, joint transcendence is featured as the core category.

Insights for nurse administrators, educators, researchers, and clinicians are provided. In addition, several broad insights for those who work in human services fields are suggested. One of the legacies of this study is an abundance of questions for continued exploration which could lead to further development of a unique knowledge base for nursing.

ACKNOWLEDGEMENT

I am grateful to the exceptional nurses who were co-participants in this study. They gave generously of their time and of themselves. Their stories and insights are the centerpiece of this dissertation.

In everyone's life there are people who will never be forgotten. The three members of my supervisory committee are on my unforgettable list. They all touched my life over the past four years. I will always be grateful to my advisor Dr. E.W. Ratsoy for his kindness, patience, and concerned council. For being a role model and an inspiration, I thank Dr. B. Young. Dr. D.A. MacKay, who is to me among the finest examples of a wise and gentle scholar, will always travel with me in my heart.

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If the bud of a flower
is pried open too quickly
the blossom may be destroyed.
(O'Banion & O'Connell, 1970)

Yet if it is never given
encouragement to bloom,
it will also wither and die
never having shown the world its color.

Chapter 1

INTRODUCTION

Within most disciplines there are those who are recognized by their colleagues as being exceptionally competent practitioners. These people are sometimes called "expert," "unusually competent," or "extraordinary." Their commonality is that they do their work in a remarkable way and their actions and interpersonal interactions are regarded as highly successful.

The purpose of this study is to explore the beliefs and actions of some clinical nurses who are considered by their peers to exhibit this quality of exceptional competence. This investigation centers on the broad question: What is the nature of exceptionally competent nursing practice? To realize at least a partial answer to this general question three more specific sub-questions were identified for investigation.

1. What do these exceptionally competent nurses believe about health, nursing, human beings, the nursing milieu, the nurse-patient relationship, life and death, and self?
2. What actions and interactions do these exceptionally competent nurses use in providing nursing services?
3. What are the effects of these actions and interactions?

I believe that researchers are drawn to study that which has personal significance. In many ways, a dissertation is an extension of the author. I have been a nurse for nine years. This, combined with a regard for exceptional people, a personal interest in self-improvement, and a desire to help other nurses strive for excellence, attracted me to this topic. My experience has been as an oncology nurse, therefore I focused my study on nurses who care for people with cancer.

SIGNIFICANCE OF THE STUDY

This study may be meaningful to the profession of nursing, clinical nurses, nurse educators, nurse researchers, and nurse administrators. In a broad sense, findings from this research could have significance for practitioners and theoreticians employed in human service fields other than nursing.

Significance for the Profession of Nursing

According to Polit and Hungler (1993), the expansion of nursing knowledge is essential for the continued growth of the profession and for helping nursing to achieve its own professional identity. As Leininger (1985a) states in the preface to her book on nursing research, "Most of all, there is a need for exploring and examining the nature and essential features of nursing" (p. xi). In part, this project was undertaken in response to this challenge. Findings may assist in developing and reconceptualizing a body of knowledge specific to nursing.

Since the beginning, nursing primarily has been based on a medical model. Only recently have some nurse researchers gone beyond this model and focused on identifying and describing what is unique to nursing. This study enhances our understanding of exceptional oncology nursing practice, adding one more portion to the profession's body of knowledge.

Allen and Jensen (1990) report that, "One of the philosophical problems discussed within nursing is what kinds of knowledge are of most value to the discipline" (p. 241). They conclude that, "The value of knowledge in nursing is, in part, determined by its relevance to and significance for an understanding of the human experience" (p. 241). This discussion and description of exceptionally competent nursing practice contributes to such an understanding.

Significance for Clinical Nurses

The nurses who participated in this project are clinical nurses, individuals who spend the majority of their work time providing nursing services to patients directly. I believe that this research has meaning for them. Encouraging clinical nurses to tell their stories and share their experiences gives these exceptional people a voice. Research such as this acknowledges that what they do has value. Through involvement in this study the nurses participating stated that they gained increased personal awareness. Being chosen as an exceptionally competent nurse recognized their excellence, and potentially increased their sense of self-worth.

Focusing the study on practitioners is a salute to the important role they play in the health care system. This study helps make visible the often hidden, but significant, work of clinical nurses. Indirectly, it increases the value of nursing by disclosing what is embedded in clinical practice.

I expect that clinical nurses who read this work will see elements of their practice reflected in the descriptions of the care provided by their exceptionally competent colleagues. Nurses often work in isolation. Reading about the practice of others can be a method of learning alternative practice approaches. In this way, the examples may serve as models for beginning nurses, helping them learn both the tangible and the less tangible components of excellent practice. Practitioners who find they use techniques and achieve effects similar to those described by the study nurses may feel reassured that their care is probably also excellent.

Significance for Nurse Educators

This study has potential value for nurse educators. As they read this study, they may become sensitized to the value of narratives and descriptions of practice as teaching tools.

Some of the descriptions provided are examples of how the nurses studied achieved their current level of competence. From these, nurse educators can draw ideas to increase the effectiveness of their teaching. There are also worthy insights in this dissertation for nurse educators concerned with providing continuing education for those who are already excellent practitioners.

Significance for Nurse Researchers

For researchers, this study is a source of unanswered questions. I anticipate that nurse researchers may use the descriptions, the questions raised, and the insights articulated, to stimulate their ideas and hypotheses for future research.

The research methodology employed is an unusual combination of qualitative methods. Nurse researchers may find this work an example of how different recognized approaches may be aligned, resulting in a unique way of gathering, interpreting, and presenting data. Carter (1985) encourages innovative research methods saying, "Nurses who are willing to take the bold steps in new and different approaches to research will advance nursing's evolution most rapidly and will emerge as the true leaders of the profession" (p. 31). Researchers outside of the field of nursing may also find this coupling of qualitative methods transposable to their own explorations.

Significance for Nurse Administrators

Nurse administrators may use the findings of this project in several ways. For example, it may benefit them to have descriptions of the more intangible and immeasurable aspects of nursing practice. These findings can be used to aid in justifying and supporting the unique role nurses fulfill within health care institutions.

Presently, the parameters of nursing within the health care system are vaguely defined. Nursing investigations such as this are useful to administrators as they attempt to define and defend the distinctive role that nursing has in the delivery of health care.

Featuring exceptional nurses and what they do and think may aid in the development of standards to which other nurses may be compared, and against which nurses may gauge their own achievements. This could have implications for methods of personnel evaluation.

In their capacity as leaders, nurse administrators may find the narrative method a useful approach to mentoring and modelling for their employees. Nurse administrators, after observing the powerful messages embedded in the narratives in this dissertation, may see the value in sharing some of their own stories as an approach to leadership.

Significance for Human Services Personnel

Finally, this study is potentially important for people engaged in human services work. Besides nurses, others who are employed in health related fields, as well as educators and administrators, may gain from reading this dissertation.

In one sense this study is part of a greater search for what it means to be human. As we search for meaning in our experience, and in the experience of others, we gain a fuller grasp of what it means to live in this world. Van Manen (1990) claims that through such an exploration we "become more fully aware of who we are" (p. 12). Those whose responsibility it is to provide service to others may find they are better able to achieve their goals if they first have a greater understanding of themselves. This dissertation contains guidance for those who seek to become exceptionally competent no matter what their field of service.

The nature of nursing is such that each day practitioners face some of the most fundamental and poignant issues confronting humanity, for example, issues surrounding life and death. Understanding the beliefs of exceptional nurses may also illuminate our broader understanding of such issues. Ellis and Flaherty (1992) contend that "little has been done to unravel the complex manner in which emotion, cognition, and the lived body intertwine" (p. 3). I believe that this study begins to unravel this mystery.

In summary, this dissertation may have significance for the nursing profession, for nurse practitioners, educators, researchers, and administrators, and for people who are engaged in human services work. The realities recorded and analyzed in this study will contribute to the growing body of knowledge that the profession of nursing considers its own. This work is an uncovering and sharing of some of the intimate liaison which occurs between nurse and patient, a relationship which has long remained concealed and unrecognized. Benner and Wrubel (1989) conclude that examples of excellent nursing service, such as those highlighted in this study, can be used as the basis for new visions of practice (p. 21).

Beyond clinical practice, this research project also has implications for research and theory. The relationship between these three is reciprocal and complex. Theory guides research, while research contributes to theoretical knowledge. Both theory and research guide clinical practice. However, theory must also come from those nurses who have the most intimate contact and the greatest responsibility for patient care. Those who know nursing most personally must be given the chance to tell their stories and thereby contribute to meaningful nursing theory. This study provided such an opportunity.

DEFINITION OF TERMS

Three terms that are important to understanding this dissertation require definition.

Oncology nurse - a nurse who provides nursing services to patients who have a diagnosis of cancer.

Exceptionally competent nurse - for this study, those nurses nominated by their peers as the nurses they would want to have provide nursing services to them or their family members if they became ill with cancer.

Palliative care -

> refers to programs or services that provide care to those patients for whom treatment aimed at cure and prolongation of life is no longer appropriate but for whom therapy aimed at improving the quality of the remaining life is the primary objective. Palliative

> care offers therapeutic services designed to address the physical, psycho-social, intellectual, and spiritual needs of dying patients and their families. (McHutchion, 1987, p. 334)

ORGANIZATION OF THE DISSERTATION

This chapter serves as the introduction to the dissertation. The major topics addressed are the research questions, the significance of the study, and the definition of important terms.

The second chapter focuses on the design of the research. A discussion of the two qualitative methods used, grounded theory and hermeneutic phenomenology, is central to this chapter. The philosophical and methodological features of these methods are presented and compared. Specifics about the study participants, channels for data gathering, and data analysis are discussed. Finally, Chapter 2 includes descriptions of techniques used to maintain data trustworthiness, the pilot study, the assumptions made, the delimitations and limitations of the study, and a discussion of ethical considerations.

In the third chapter part of the contextual basis for the study is set. I share my most vivid memories of oncology nursing in an attempt to establish a landscape against which a description and discussion of exceptionally competent oncology nursing practice can be placed. These memories also introduce me to you, exposing some of my values and possible biases and allowing you to decide how I may have influenced the data collection and analysis. To expand this scene, a brief review of published literature on the nature of oncology nursing and comments from some of the exceptional nurses on their views related to oncology nursing are included.

The second half of the contextual basis is provided in Chapter 4. This material is drawn from a discussion of models of nursing from the literature interwoven with a description of the beliefs expressed and demonstrated by the exceptional nurses studied.

Chapters 5, 6, and 7 include the initial findings of the research, specifically, some of the actions and interpersonal interactions of the exceptional nurses. Each chapter centers on a specific theme and an understanding of the theme is achieved through hermeneutic analysis. Stories, quotations, observational accounts, relevant literature, and poetic analysis are included. The three themes described are a dialogue of silence, mutual touch, and sharing the lighter side of life.

Chapter 8 is a grounded theory analysis of the data. Using three levels of coding, concepts and categories are identified and possible interrelationships of categories considered. The effects of the nursing actions and interactions described in the earlier chapters are specified.

A hermeneutic analysis of the effects of the nursing actions identified in Chapter 8 is the focus of the ninth chapter. In this chapter the essence of the experience of exceptionally competent nursing practice, joint transcendence, is described. Other effects of the actions and interactions discussed in the eight chapter include connecting and affirmation of value of the patient and the nurse. Again the stories and words of the nurses and poetic analysis are featured in the discussion.

Major insights, unanswered questions, ideas for further research, and implications for clinical nurses, nurse educators, nurse researchers, nurse administrators, and human services workers are presented in the tenth and final chapter.

Chapter 2

RESEARCH DESIGN AND METHODOLOGY

CHAPTER INTRODUCTION

The focus of chapter 2 is a description of the design of this study and the methods used. The chapter opens with a discussion of the nature of interpretive inquiry. A case is made for its use in nursing investigations that focus on human experience. A discussion of the advantages and disadvantages of coupling two credible qualitative methods: grounded theory and hermeneutic phenomenology is a feature of this chapter. The advantages are summarized and it is argued that the combination of these approaches in this study results in a more complete understanding of exceptional nursing practice. Specifics about the study participants, channels of data gathering, and data analysis are also discussed. Finally, the techniques used to maintain data trustworthiness, the pilot study, the assumptions made, the delimitations and limitations of the study, and a discussion of ethical considerations are furnished.

THE NATURE OF INTERPRETIVE INQUIRY

Until very recently most published nursing research "reflected a deductive theory-testing epistemology" (Chenitz & Swanson, 1986, p. 26). The deductive method was viewed as the most valid and reliable way to gain knowledge and understand nursing experience. However, a change is occurring.

Noted nurse researchers Benner and Wrubel (1989) conclude in their text The Primacy of Caring that, "The languages of positivistic social science and the natural sciences are too impoverished to give an adequate account of what actually occurs in everyday life" (p. 41). In an article criticizing the use of scientific method in nursing studies, Kikuchi and Simmons (1992) write, "Disillusioned with the positivistic approach to science, many nurse researchers have turned to other approaches and, in so doing, have stretched the scope of science as traditionally understood" (p. 5).

Sharing a similar view, Leininger (1985a) proposes that "alternative research methods can help nurses to discover the complex holistic and humanistic care dimensions of human thought and action" (p. xi). Leininger contends that the full nature of nursing can only be grasped by focusing on the whole, not by testing isolated aspects (1985a, p. 23). Carter (1985) agrees saying "research methods based upon reductionism can never capture the elusive qualities of phenomena that nurses know exist" (p. 30).

According to Harman (1988), "The time has come to tiptoe no longer, but to quietly, firmly, and self-confidently insist on the need for restructuring of science to accommodate all, rather than just part, of the human experience" (p. 21). Watson (1985) adds, "To develop a knowledge base nurse researchers should choose methods that allow for the subjective inner world of personal meaning to be revealed" (p. 345).

Heeding this advice, I have designed and conducted an interpretive research study. The goal was to investigate human thought and action, therefore interpretive methods of inquiry seemed to be the most suitable. The assumptions, premises, and expectations of this mode of research are most congruent with the traditional values of nursing as a personalized, intimate, and holistic human service.

Interpretive research has as its goal the full description and interpretation of whatever is being investigated, within particular contexts, from the participant's viewpoint. An interpretive researcher attempts to "grasp the essential features of what is being studied so the essence and nature of the person, object, and actions of study are revealed" (Leininger, 1985a, p. 5).

To accomplish this goal interpretive researchers enter the participant's world to gather information first-hand through oral and written accounts, symbols, language, and observation. As Leininger (1985a) defines it, the approach is one of open discovery, characterized as a flexible, dynamic, evolving approach where the researchers may reformulate and expand the focus of the study as they proceed (p. 6).

In trying to describe an experience that is complex and interpersonal, such as exceptional nursing practice, the researcher chooses a method that requires minimum structure and maximum researcher involvement (Polit & Hungler, 1993, p. 325). To discover the elusive, vague, and still largely unexplored nature of exceptional nursing practice a descriptive approach that follows the assumptions and premises of interpretive inquiry appears to be most appropriate.

The goal of this study is an exploration of the nature of nursing. To succeed in such a quest a method that encourages close contact with the participants in context and that focuses on the whole is necessary. As Leininger (1985a) succinctly states, "Interpretive types of research are the essential means to know and understand phenomena of nursing" (p. 23).

CHOICE OF METHODOLOGIES: A COUPLING OF TWO APPROACHES

Van Manen (1990) claims that methodology

> refers to the philosophic framework, the fundamental assumptions and characteristics of a human science perspective. It includes the general orientation to life, the view of knowledge, and the sense of what it means to be human which is associated with or implied by a certain research approach. (p. 27)

In other words, methodology is the theory behind the method. Van Manen adds, "Methods used need to be discovered or invented as a response to the question at hand and they need to be congruent with the methodology chosen" (1990, p. 29). In this section it is the methodology that is the primary focus. Once the methodology is clear, the methods to be used become evident.

Interpretive studies share similar goals and methods but there are a variety of theoretical and philosophical traditions that fall within the broad umbrella of interpretive inquiry. Since each methodology has unique strengths, combining complementary approaches should result in a more intricate and complete investigation. When exploring a complex field such as nursing it seems unrealistic to believe that a single approach can describe adequately the phenomena under investigation. From this thinking was born the idea of coupling interpretive methodologies. I have chosen to weave together hermeneutic phenomenology and grounded theory methodologies in this study.

Combining two approaches based on different but complementary philosophical traditions strengthens this research. Subtleties that were overlooked with the use of one process were revealed in using the second approach. Likewise, themes identified using the first methodology were illuminated further by a second technique.

The merging of methods was a way of looking at the same data from two different perspectives, leading to multiple interpretations. A richer, more detailed picture of exceptional nursing practice was the result. In the words of Wilson and Hutchinson, coupling the two methodologies "provides both the rich detail of human experience that can inform our practice and analysis at a conceptual level that suggests interventions, or hypothesis that can be used for subsequent quantitative research" (1991, p. 265).

What follows is a discussion of the philosophical and methodological features of each methodology employed and a description of how combining these two resulted in a deeper and richer understanding of exceptional nursing practice. For clarity, the essential features of hermeneutic phenomenology and grounded theory are presented first, followed by a comparison of the approaches and an argument for their compatibility.

Hermeneutic Phenomenology

Hermeneutics is an approach to studying human beings that is rooted in philosophy and based on the views of phenomenologist Martin Heidegger (Wilson & Hutchinson, 1991). According to van Manen, hermeneutics is the interpretive study of the expressions of lived experiences in the attempt to determine the meaning embodied in them (1990, p. 38).

Phenomenology is the study and description of human phenomena. As van Manen (1990) explains, the terms phenomenology and hermeneutics are often used interchangeably, however, phenomenology focuses on the "lived experience" whereas hermeneutics refers to the interpretation of the experience (p. 7).

Gaut (1981) uses the two words in combination, defining hermeneutic phenomenology as the interpretation of concealed meaning within a phenomenon. It becomes difficult and perhaps unnecessary to differentiate between hermeneutics (the interpretation) and phenomenology (the description) since at one level of understanding a description is itself an interpretation. Oiler (1986) also uses the two terms in tandem and states that hermeneutic phenomenology is recognized as a valuable approach to uncovering meaning and describing experience.

A basic tenet of phenomenology, both as a philosophy and a method, is that each person is unique and possesses potential. Researchers who pursue phenomenological studies ask the question: "What is the essence of this phenomenon as experienced by these people? Phenomenologists assume that this essence can be described and understood" (Polit & Hungler, 1993, p. 328).

Merleau-Ponty (1962) explains that "the word `essence' should not be mystified.... Essence may be understood as a description of a phenomenon" (p. 39). The essence is "a linguistic description that is holistic and analytical, evocative and precise, unique and universal, powerful and sensitive" (Merleau-Ponty, 1962, p. 39). According to van Manen, "The essence or nature of the experience has been adequately described in language if the description reawakens or shows us the lived quality and significance of the experience in a fuller or deeper manner" (1990, p. 10).

Van Manen (1990) describes the characteristics of phenomenological research. It begins in the world of those being studied. Lived experience is the starting point and end point of phenomenological research. "The aim of phenomenology is to transform lived experience into a textual expression of its essence" (van Manen, 1990, p. 36). In van Manen's view, the phenomenological investigation does not result in a theory with which the world can be explained, rather it offers "plausible insights" that bring us all in more direct contact with the world (1990, p. 9).

The focus of phenomenology is on meaning, and the goal is to explicate meanings as we experience them in our everyday existence. Hermeneutic phenomenology is a human science which studies persons. It is not interested in the generalizable, it is a philosophy of the unique, interested in what is essentially not replaceable (van Manen, 1990, p. 7).

Heidegger (1962) describes phenomenological research as a minding, a heading, a caring attunement. To van Manen it is "the attentive practice of thoughtfulness" (1990, p. 12). The latter cautions, "To do hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the life world, and yet to remain aware that lived life is always more complex than an explication of meaning can reveal" (1990, p. 18). Despite this cautionary note, an attempt at the impossible still has merit. Though a description can never be complete, it does bring us closer to an understanding of a phenomenon.

There is no step by step method for doing phenomenological research. Merleau-Ponty (1962) advises that the only way to learn it, and understand it, is to do it. Gadamer (1975), supporting this position, writes that the method of phenomenology and hermeneutics is that there is no method.

Although there is no specific method or program, there is a tradition, a set of guides and recommendations. In doing phenomenology the researcher searches for "the critical moments of inquiry." These moments are ultimately elusive to systematic explication. As van Manen states, "Such moments depend more on the interpretive sensitivity, inventiveness, thoughtfulness, scholarly tact, and writing talent of the human science researcher" (p. 34). Benner and Wrubel (1989), nurse researchers who use phenomenology in their work, maintain that the products of hermeneutic phenomenology inquiry may include "thick description," "paradigm cases," "exemplars," and "thematic analysis" all of which explicate meanings and ways of being.

The hermeneutic phenomenology approach in this investigation contributes to our understanding of the experience and it can inform the way we think and feel about nursing practice. In brief, what hermeneutic inquiry contributes is the rich contextualized detail of this human experience.

While the goal of hermeneutic phenomenology is not to extract theoretical terms or concepts at a higher level of abstraction (Benner, 1984, p. 10), grounded theory methods may assist the researcher to produce a beginning conceptual understanding. In this way, grounded theory is useful as an adjunctive method.

Grounded Theory

To understand the philosophical underpinnings of the method known as grounded theory it is important to know that it has "its roots in the social sciences, specifically, in the symbolic interaction tradition of social psychology and sociology" (Chenitz & Swanson, 1986). Symbolic interaction is a theory about human behavior, an approach to the study of human conduct and human group life. It focuses on the meaning of events to people in everyday settings and the way this meaning guides behavior.

George Mead and Herbert Blumer are given credit for the advancement of symbolic interaction tradition. In his 1969 text Symbolic Interactionism: Perspective and Method Blumer suggests that symbolic interaction rests on three basic premises:

> Human beings act toward things on the basis of the meanings that the things have for them; meaning of such things is derived from, or arises out of the social interaction that one has with one's fellows; and these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters. (p. 12)

The basic belief, in the words of Chenitz and Swanson, is that,

> nothing in the world...has intrinsic meaning or inherent value in and of itself. Meaning is created by experience. Through interaction with the object and

> with self, the object is defined. Once defined, meaning can be attached to it. The meaning the object has to the individual gives it value. (1986, p. 5)

Symbolic interactionism focuses on the social construction of reality. An interactionist perspective maintains that individuals interpret others' actions and respond to those actions based on their interpreted meaning of them. That is, responses are constructed socially by continually interpreting the meaning of stimuli.

Responses are based upon interpretation of others' acts and interpretations depend on a personal value system in combination with situational experience. For example, a nurse's personal values and attitudes toward the death experience in combination with the perceived needs of a particular patient at a given time will contribute to the nurse's interpretation of the patient's speech and gestures. This interpretation will affect the nurse's responses to the patient.

The symbolic interactionist studies behavior on both the interactional and symbolic levels. Chenitz and Swanson stress that,

> studies in this framework must include observations of behavior in a specific situation. The focus of the observation is on the interaction since it is in both verbal and nonverbal behavior that the symbolic meaning of the event is transmitted. (1986, p. 6)

The researcher who follows the symbolic interactionist philosophy attempts to understand the behavior of the participants as they understand it.

Symbolic interactionism can be summarized by Blumer's

(1969) root images:

> 1. Any scheme of human society must respect that human society consists of people engaging in action. Consequently, any study of human behavior needs to focus on the action.
>
> 2. People base their own actions on what they have encountered and interpreted from the actions of others.
>
> 3. The same object may have different meaning for different people. However, common objects may emerge that have the same meaning for a given set of people. The meaning of objects has to be formed, learned, and transmitted to others through a social process.
>
> 4. A human being can be an object of his own action. The self object emerges from the process of social interaction in which other people are defining a person to himself. Therefore, social interaction includes interaction with self as well as with others.
>
> 5. People ascertain the meaning of the actions of others and then proceed to map-out their reactions. Human behavior is a process of noting, assessing and interpreting, planning action, and action.
>
> 6. Joint actions occur where there is interlinking of separate actions of group members. This occurs when people share common pre-established meanings. (p. 12-15)

Symbolic interactionists view humans as powerful, influential beings who are active participants in all of their actions. The self is elevated to a position of importance as the individual is viewed as having the ability to interact with the self in determining courses of action. Each person's world is unique because each object in a being's world is given meaning by that person.

Grounded theory uses the symbolic interactionist perspective to provide a way to study human behavior and interaction. The theoretical construct of symbolic interactionism provides a framework within which observations and descriptions can be analyzed. Since, according to symbolic interactionism, human behavior is determined by interaction with others, grounded theory researchers need to attempt to understand behavior from the participant's point of view. Grounded theorists study people in the social world which they inhabit.

In describing grounded theory Strauss and Corbin write, "A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, the theory is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon" (1990, p. 23). It may involve theory generation and preliminary verification in addition to description.

The term grounded means that the research is based on the actual, concrete realities of people as they live through their experiences (Boyd, 1990). Coupled with the word theory, grounded theory refers to theory that is constructed from a base of observations of the world as it is lived by a group of people.

The grounded theory approach was first articulated by two sociologists, Barney Glaser and Anselm Strauss in 1967. According to Stern (1980) there are two main uses for grounded theory, in "investigations of uncharted waters or to gain a fresh perspective in a familiar situation" (p. 20). This investigation proceeds into relatively new territory, therefore grounded theory methods are appropriate. In this study grounded theory is also used to gain a fresh perspective following a hermeneutic analysis of the data.

The aim of grounded theory is to understand how groups of people define reality and to communicate this in the form of theory. It may create theory where no theory exists. To produce theory, themes are identified and they are related to one another in a conceptual scheme through a process of interpretation and conceptualization called the "constant comparative method" of analysis (Chenitz & Swanson, 1986).

Glaser and Strauss (1967) claim that if the theory is carefully developed and fits the area that was studied it should provide insight for those who practice in the field. A broadly generated theory based on comprehensive and diverse data may be generalizable to a "variety of contexts related to those phenomena" (Glaser & Strauss, 1967, p. 237). Finally, according to Strauss and Corbin (1990) such a theory should guide action toward phenomena studied.

Comparison of Hermeneutic Phenomenology and Grounded Theory

As indicated earlier, I have chosen to combine hermeneutic phenomenology and grounded theory approaches in an attempt to develop a more comprehensive understanding of exceptional nursing practice. Before proceeding it is important to establish that some congruence and harmony exists between the approaches. In addition, I plan to demonstrate that a synergy occurs between the two which, in this study, resulted in a more complete description and understanding of exceptional nursing practice.

The overview of the philosophical basis of the methodologies has illuminated some of the commonalties and differences. What follows is a detailed comparison of the two approaches. Table 2.1 summarizes the key considerations.

TABLE 2.1

A COMPARISON OF ELEMENTS OF HERMENEUTIC PHENOMENOLOGY AND GROUNDED THEORY

HERMENEUTIC PHENOMENOLOGY	GROUNDED THEORY
Derived from the philosophy of phenomenology	Derived from symbolic interactionism
Behavior studied in context, direct contact with participants	Behavior studied in context, direct contact with participants
Based on actual realities of people as they live through their experiences	Based on actual realities of people as they live through their experiences
Emphasizes meaning, lived experience, textual expression of the essence	Emphasizes meaning, experience, and social interaction
Meaning guides behavior	Meaning guides behavior
Goal - discover meaning and understanding	Goal - extract theoretical ideas and concepts
Focus on understanding	Focus on theory about phenomena

phenomena	
Does not attempt to generalize	Attempts high level abstraction
Analysis and data collection occur simultaneously	Analysis and data collection occur simultaneously
Interviews are main method of data collection	Interviews, observations, and document analysis used to gather data
Interpretation - unveil hidden meaning	Interpretation - discover themes, link concepts, suggest further questions
Analysis generates exemplars, cases, and themes	Analysis generates codes, categories, and sometimes theory
Data left intact	Data broken down, conceptualized and put together in new ways
Literature review serves as background meaning for analysis	Literature review serves to sensitize researcher to concepts and to validate findings
Search is for the essence	Search is for the core variable
Validity is checked by participants responding to textual expression of the essence	Validity is checked by participants responding to themes and proposed theory
Provides rich detail that can inform practice	Provides analysis at a conceptual level - suggests interventions perhaps even hypotheses
Study dependent on creative insights of the investigator	Study dependent on creative insights of the investigator

Potential in combining the two methodologies. The two methodologies are closely enough aligned that they can be incorporated into the same study, yet they are distinctive enough that they make independent contributions to the findings. In this study, I believe that these two credible qualitative methodologies used together provided an increased illumination of the questions under investigation.

In the words of nurse researchers Wilson and Hutchinson, "Such an approach holds considerable promise for nursing research and, ultimately, nursing practice" (1991, p. 267). As indicated earlier, each methodology offers a different way of knowing. And as Wilson and Hutchinson (1991) assert, combining the two offers a third level of understanding:

> The rich and insightful detail of hermeneutics provides a depth of personal understanding that creates a dialogue and a beginning for conversation. The conceptual framework...of grounded theory provides a stimulus for practical intervention and further research. Using both approaches provides the breadth and depth needed in nursing. (p. 275)

While each of these methodologies has its own integrity and provides somewhat different outcomes, Wilson and Hutchinson write that, "combining the two qualitative methods in one study can illuminate clinical realities that elude alternative approaches" (1991, p. 263).

This study was designed following the approach described by Wilson and Hutchinson in 1991. However, it goes beyond their discussion of the possibility of combining methodologies and provides an example of how their idea can be applied in the field.

Similarities between the two methodologies. From Table 2.1 it is evident that hermeneutic phenomenology and grounded theory have many similarities. Though they also have some differences, these divergences do not render the two incompatible, rather the differences are responsible for the uniqueness of the contributions made by each methodology.

First, both hermeneutic phenomenology and grounded theory are human science approaches that aim at increasing our understanding of human experience through description and interpretation. The commonality in their philosophical basis is a centering on the study of the inner aspects of human experience. For instance, they both focus on how people define events or reality and how people act in relation to their beliefs (Chenitz & Swanson, 1986). In other words, the two methods similarly are concerned with the realities of people as they live through their experiences.

The focus of both phenomenological and grounded theory research is human behavior. While phenomenologists search for hidden meaning behind behavior, grounded theorists focus on the meaning of an event to people. This is a subtle difference. More important is the commonality; they both hold the philosophy that meaning guides behavior.

It is of practical significance that data for hermeneutic and grounded theory interpretation can be gathered simultaneously. Interviews are the main method used by phenomenologists, while grounded theorists combine interviews with observations and sometimes document analysis. In both cases analysis and data collection occur concurrently. It is possible to combine the methodologies in part because they both suggest discovery can be made only by direct contact with participants. The context is important in both approaches.

The literature review in phenomenology enhances the researcher's background understanding and assists in the search for the hidden meaning. In a similar way, grounded theorists use the literature review to sensitize them to emerging concepts and as a verification of themes and theory.

In both processes validity is checked by the participants who respond either to the textual expression of the essences or to the proposed themes and resulting theory. Data analysis in the two approaches is similar in that its quality is dependent, at least in part, on the creative insights and perceptiveness of the investigator.

Differences between the two methodologies. In all instances grounded theory and phenomenology are congruent to such an extent that they can be used together effectively in the same study. While there are differences as reflected in Table 2.1, these differences are such that they facilitate the unique contribution of each methodology.

Both phenomenologists and grounded theorists emphasize a search for the meaning of an experience. Phenomenologists are content to discover the meaning and achieve understanding through a description of an experience, while grounded theorists proceed to seek further understanding of the interrelationship between key components of the experience, to produce theory. Phenomenologists focus on understanding phenomena, while grounded theorists focus on developing theory about phenomena.

The major discrepancy comes in the treatment of the data. Phenomenologists leave data intact. Stories and conversations are reported with contextual details complete, usually in the participant's words. Alternately, grounded theorists fragment the data into concepts, themes, and categories before putting them back together in new ways to help formulate theory.

Hermeneutic analysis may result in exemplars, paradigm cases, and themes. Grounded theory analysis also searches for themes, however, the analysis is carried out in a more structured and systematic way. A grounded theory analysis may focus on description only, or with additional coding theory may be the final product.

The end product of hermeneutical inquiry provides the rich detail that conveys the context and the humanness of the experience. It is a means of "arriving at a deeper understanding of human experience" (Allen & Jensen, 1990, p. 241). Grounded theory provides a different analysis at a more conceptual level that suggests possible interventions and questions for further research.

The aims of the two methodologies are different. The aim of a hermeneutic study is to describe and interpret participants' meanings and practices, while the aim of grounded theory is to reveal and explain the social processes. However, both goals can be achieved simultaneously, and without compromising the values of either methodology. The result is what I believe is a more complete picture of phenomena.

In summary, in this study, hermeneutics helped reveal the shared meanings and practices of exceptional nurses; while grounded theory uncovered the components and guided the formation of a beginning conceptual understanding of exceptional nursing practice.

Morse (1990) supports an innovative research approach such as this, commenting that, "Qualitative researchers must be left to do their own thing, however marginal that may initially appear, for this is one area in nursing where the true breakthroughs will be made and new directions identified" (p. 20).

RESEARCH DESIGN

This section focuses on the participants in the research, the channels used to gather the data, data analysis techniques, the pilot study, data trustworthiness, assumptions made, delimitations and limitations of the study, and ethical considerations. Each topic is considered in detail in the following sub-sections.

The Participants

The general principles employed when selecting a group of participants in interpretive research are appropriateness and adequacy (Morse, 1991). Appropriateness refers to the degree to which the choice of informants and method of selection fits the purpose of the study. Adequacy is related to sufficiency and quality of data. If the sample is "efficient," that is the respondents freely provide insightful and numerous comments and examples, and there are many opportunities for meaningful observations, the size of the sample can be small and still be adequate (Morse, 1991). It is desirable to have informants who are articulate, reflective, patient with the process, and willing to share their views with the researcher. To ensure appropriateness and adequacy the researcher must have control over the sample.

My goal was to locate a group of nurses who were considered by their peers to be exceptionally competent practitioners. I had narrowed my clinical study area to that of oncology, so I attempted to find oncology nurses who met my criterion.

After gaining access to the cancer unit of a large urban hospital I distributed letters through the hospital mail system to all registered nurses who worked in the unit. In the letter I introduced myself and my research idea, and asked them to independently construct a list of names of the nurses in their unit who they believed were exceptionally competent. A copy of the letter sent to the nurses is included in Appendix A. This method of selecting exceptional practitioners had been used in studies of expert nurses (Benner, 1984), and excellent physicians (Elstein, Shulman, & Sprafka, 1978). Benner and Wrubel (1989) report that expert nurses are easily identified by asking for nominations from their colleagues.

To clarify for the nominating nurses what I meant by "exceptionally competent," I asked them to consider those nurses who they would choose to have care for them or their family members if they became ill with cancer. In my view this was the essential criterion, the one that would encompass many of the significant aspects of excellent practice.

The nurses were free to nominate themselves, and any other nurses from their unit that they believed met the criterion. To increase their level of comfort in participating in this exercise, the nurses were assured that no nurse would ever know for certain if he or she had been nominated, except for the nurses who were invited to participate. This was facilitated by choosing the study participants randomly from the list of nominated nurses.

The written, anonymous, nominations were collected by the unit manager in sealed envelopes and delivered unopened to me. During the three week period between the distribution of the letter requesting nominations and the submission of the nomination lists, I was available in the nursing unit at specified times to answer questions and address concerns regarding the investigation.

The names of those nominated were compiled and compared. Of the 30 nurses who were asked for nominations, 25 responded to the request. There was remarkable consistency among the lists of nominees. The same names appeared on most of the nomination forms to such an extent that I felt comfortable that I had a pool of exceptionally competent nurses from which to choose. I compiled a master list of nurses who were nominated at least 20 times. From this list two nurses were randomly selected to be pilot study participants. Four additional nurses were chosen to participate in the post-pilot phase of the study.

The nurses who were selected as participants were sent letters inviting them to partake. Those interested in becoming study participants signed an informed consent form and returned it to me. All the nurses who were approached agreed to be in the study. The names of other nurses who were nominated, but who were not randomly selected as participants, were kept in reserve.

As the study unfolded I became intrigued that the names of oncology nurses who worked at various other institutions were mentioned frequently in conversations. A variety of health care providers, including the exceptional nurses I was studying, would say, "Have you interviewed _____? You really should because to me she [or he] is really exceptional."

Most times the exceptionally competent nurses whose names were volunteered in this way were nurses who worked in other cancer hospitals, sometimes in other cities, and who had reputations for excellence in the oncology community. I extended my study population by contacting two of these nurses for additional insights into exceptional practice.

In the end my sample consisted of eight nurses who worked in three different cancer settings. All eight nurses were nominated by their peers as being exceptionally competent practitioners. The data collected during the pilot study were included in the final analysis because they had become part of my experience and were therefore difficult to separate from the post-pilot data.

Who are the exceptionally competent nurses who were studied? Rather than specifying the demographic profile of each nurse individually I decided to provide a composite picture of the nurses who participated. This takes the form of a description of the daily routine in the oncology unit where the study was based. The nurses described in this scenario are the eight study participants.

This illustration should be valuable in several ways. First, it includes a depiction of the nurses I observed, letting you see the pertinent demographics of the study participants. Though they are all unique in certain capacities, it is interesting that their demographics overlapped in many spheres. Second, this description provides an example of the routine followed by a clinical oncology nurse working in the unit studied. An enhanced understanding of the context of oncology nursing should result from this example. Third, after reading this description you should have a beginning appreciation for the setting in which the study took place.

While no two days, or two shifts, or two nurses were exactly the same, there were similarities that make it possible for a composite description of an average day to be constructed. Although this day is fictitious in its totality, it is accurate in its individual details. One factor that all the nurses studied had in common was that they had been (or still were) primary care-givers for hospitalized cancer patients.

An average day in the unit. It's 0700 hours and the eight registered nurses participating in the study (Jane, Maureen, Marie, Julie, Lana, Peter, Moria, and Mindy) have gathered around a table in the conference room to listen to a tape-recorded report on the condition of each patient staying in their unit. The details of the report are provided by the nurses who are just finishing the night shift. As I look about the room, I am surprised at how alert the staff members look. I secretly wonder how they can exude so much energy at this hour of the morning.

They have dressed thoughtfully. One is wearing a peach colored uniform with a lace collar that she crocheted herself. Another wears a bright smock over her uniform. "We need a little color around here," she chirps when one of her colleagues comments on her outfit. As they wait for the nurse in charge to enter the conference room and begin the report the nurses enthusiastically exchange tales about their last evening's activities and their families.

They are all women, except one, and the oldest of them has not reached her sixth decade, the youngest is 29. All but one are married. Most of the married nurses have children varying in age from toddler to young adult. Each nurse has worked in the unit for a minimum of two years, the most senior has eleven years of oncology experience. For one woman nursing is her third career. She had been a teacher and a school principal before becoming an oncology nurse two years ago. One nurse had 20 years of experience in the operating room before transferring to the cancer unit two years before. Stories of juggling the needs of their children, spouses, community, and other commitments permeate the conversations. "How do they do it all and work full-time too I muse?"

Outside the closed door of the conference room, the night shift nurses hurry to finish their last minute tasks such as making notes on each patient's chart, answering patient call bells, and storing equipment used during their shift.

Closeted inside the conference room, away from patients and family members, the day nurses and I listen closely to a tape-recorded voice giving us the jargon-laden details of each patient's condition.

"Mr. Jakes in room 10 slept well and needs to have an urine specimen collected this morning. Mrs. Kennedy in room 12 is due at X-ray today and her intravenous bag has 100 ML to be absorbed. Mr. Millright in room 14 experienced a lot of pain during the night and needed analgesic medication every three hours. He is due for a scan today."

The report goes on until details of each patient have been recounted. The nurses have recorded carefully the pertinent information regarding the patients assigned to them and as the voice on the tape-recorder says, "Have a good day shift," the nurses gather their notes, place them in their uniform pockets, and set-off to do "morning rounds." As they leave the conference room the nurse in charge calls out words of encouragement saying, "We are short one nurse today. Marj called in sick. It looks heavy. Let's work together!"

Each nurse is assigned to give care to a group of patients. The patients who are critically ill or close to death stay in private rooms, others may be in semi-private accommodations. The number of patients in the assignment varies depending on the amount of care each patient requires. Jane, one of the nurses, has six patients today, while Maureen has one very ill man to care for.

Morning rounds consist of a quick check on the patients to meet any immediate needs such as trips to the bathroom, intravenous bags that need replacing, or realignment of patients who are uncomfortable. During rounds priorities are set and plans are made for the care to be given during the day. The common morning rounds questions include, "What time would you like your bath? Are you expecting any visitors today? What is your pain level - should we try your pain pills every three hours?"

The morning proceeds smoothly, a series of breakfasts, baths, and bed-making punctuated with administration of medications, and ongoing assessment of each patient's physical and emotional status. Interruptions by doctors seeking information, family members needing reassurance, and colleagues requiring assistance are all incorporated readily into the routine. "Routine," Peter explains, "is part of each day. You need it to make sure certain tasks get done.... It gives structure, back-bone to the more creative parts of nursing."

I am fascinated by the perpetual motion. It seems the nurses never stop moving, talking, questioning, listening, lifting, and writing. Finally, they take a break. We gather at the elevator to go to the cafeteria for lunch. The nurses take their meal break in two shifts. Before leaving the unit each nurse reports to another nurse who is staying behind, making certain all patients will be cared for in their absence.

At lunch I find out more about these nurses. They have such busy lives outside their work. For example, one collects dolls, one sews, one golfs and swims, one paints, one enjoys the outdoors and nature, one plays four musical instruments, one teaches Sunday school and is President of her community league, one has three pre-schoolers. Animated discussions tell me they are as passionate about their hobbies and interests as they are about their nursing. In conversation Lana says, "I believe that we can be better nurses if we have something else in our lives besides nursing that we really like to do."

We talk about their education. "Where did you study nursing I ask?" They have all completed a nursing diploma program. Two have finished post-basic bachelor's degrees in addition to their diplomas. Life-long learning is a value each nurse expresses and they talk about the importance of "staying current" by attending conferences, reading professional journals, and asking questions.

Our break is short because there are medications that are due to be administered, Mrs. Jones wants to go outside in her wheel chair for a few minutes, and the physiotherapist is coming to show them how to use a new lifting device that will "save their backs." As we proceed toward the elevator that will return us to the unit they make the transition in their speech back to the world of work.

The afternoon goes by quickly. It seems most of the plans made this morning have been modified and the nurses are now being driven primarily by the requests of the patients and physicians. There is a flurry of activity just before shift change at 1500 hours as the day nurses try to squeeze in time to complete the charted notes on each patient and to tape-record report for the nurses who will be working the afternoon shift. Simultaneously they greet visitors, explain changes in each patient's status to family members, and answer patient call bells with grace and cheerfulness.

There is a detectable sense of relief in the environment as the afternoon shift nurses begin to drift in. The day nurses are starting to look fatigued. Their once fresh uniforms are wrinkled and stained and their steps are a little slower. As they put on their coats to go home, they talk about how tired they are, but they still smile. There is a sense of achievement; the team has pulled together and won. Getting on the elevator to leave, Julie turns back. She has forgotten to tell her replacement nurse that Mr. Yin asked for ice-cream for supper and she wants to make sure he gets it.

Data Gathering

To be true to the tenets of both hermeneutic phenomenology and grounded theory methodology, I chose data gathering channels that ventured into the participants' worlds. Phenomenology and grounded theory accept a variety of sources of knowledge, providing human experience is studied in context. Ray (1987) contends that each experience communicated to the researcher is useful no matter how that experience is communicated.

I sought to find ways of reaching into the realities of the exceptional nurses, to try to capture how they were experiencing and intervening in their worlds. By choosing to use a combination of field-based methods including observation, multiple in-depth conversations, and narrative exchange I endeavored to get a comprehensive view of exceptional nursing practice. As Leininger (1985a) says, to discover the elusive, vague and still largely unexplored nature of human care necessitates exquisite participant observations, interviews, and other research skills associated with the interpretive research methodology. The details of my approach to each channel of data gathering are discussed in the following sections.

Each nurse was studied individually. Observations were conducted with every participant over a period of approximately 40 hours, covering a variety of shifts, and days of the week. Following, or during the observation period, I held an in-depth conversation with each individual participant.

After a period of retreat from the study site and an initial analysis of the data, further conversations were conducted with some of the participants. In addition, the process of narrative exchange was initiated with all of the participants and with the two nurses from outside the original study site. This resulted in several supplemental contacts with most participants, by mail, phone, or in person.

On two occasions I presented preliminary results of my research at conferences attended by some of the study participants. At these presentations additional opportunities for informal follow-up discussion arose.

Observation. From the beginning of my field work I recorded my observations, thoughts, and insights in a research journal. Throughout this discussion of the data collection methods I include excerpts from this log, as I think they most clearly communicate the details of the process undertaken.

My field methods were not as precise in their execution as I first imagined they would be. I did make discoveries and change my tactics as I proceeded. However, I always tried to remain very aware of what was happening, of where my research was leading me. I believe that the result of my openness to "letting go and learning from others" (Leininger, 1985a, p. 53) is an accurate and intimate picture of exceptional nursing practice.

One example of a change in my approach was a move from a more active participant-observer role to that of an observer-participant. The following journal entry details this transition.

It's 6:00 A.M. and I feel chilled as I struggle out of

> bed and put on my uniform to start another day of observations in the unit. As I drive toward the hospital and think about my plans for the day I am glad I made the decision to observe rather than participate.
>
> At first I imagined being like a second set of hands to the nurse I was observing, a participant-as-observer in text-book terms. But it just wasn't working. Sure I was a "big help," but I was missing the action as I ran here and there delivering hot water bottles, and cups of tea. The nurses were confused about what I could and couldn't do; in fact even I got confused sometimes. It's hard to remember I'm a researcher, not a nurse right now.
>
> Being more an observer is better for my purposes. Now I'm just like a shadow, I stay quiet and out of the way and I am surprised that no one even seems to notice me anymore. I think what I am observing is more real somehow, the nurses aren't performing for me anymore. They seem to have forgotten (as much as they can) that I am even there.

Pearsall (1965) describes the role continuum for participant observers, a continuum ranging from complete observer to complete participant. According to Pearsall (1965), in the observer-as-participant role the researcher remains "detached and objective," observation takes precedence. Alternatively, in the participant-as-observer role, close interpersonal relationships may develop with informants as the observer enters the social and cultural milieu of the participants.

As part of my struggle to decide what my most effective role would be, I did question Pearsall's role continuum. This entry illustrates my thinking.

> There has to be something more than observer-as-participant, and participant-as-observer. These categories are too stark, too exclusive. I really don't fit in either. I have decided not to participate in a physical sense, but in every other way I participate totally. Pearsall's label "detached observer" doesn't apply. Maybe the label isn't important as long as I

know what my role is.

Although I began with the plan to be an active participant, I did change to a less active role after phase two of the pilot study. The observer-participant role was helpful during the observation phase of the study, however during the conversations and narrative exchanges I became more interactive and intimate with the participants.

My observations were primarily of nurse-patient encounters. However, as this entry describes they were not limited to these interactions.

> I find I am observing the nurses everywhere we go...not just with patient interactions, but also when they are on breaks, in conferences, or attending rounds. Perhaps because they know I'm a nurse they seem really comfortable with me and invite me to follow them into the medication room and some of their other inside spaces.

When appropriate, brief notes regarding the observations were made during the observation period. Notes were recorded away from the scene of action, usually in the hallway, or an empty room. At the completion of every shift these comments were elaborated upon, additional remarks made, and the refined notes were entered in my research journal.

I originally planned to keep a separate diary to log "ideas, fears, mistakes, confusions, breakthroughs, and problems" (Spradley, 1980). However, it became difficult to separate feelings and observations so the two were documented in the same journal.

I contend that my experience as an oncology nurse prepared me to make meaningful observations and also to know how to observe without compromising patient care. This journal entry summarizes that struggle.

> I worried a lot at first about whether or not I would be sensitive enough to what was happening to know when it was in the patient's or nurse's best interest to step out and not observe a particular moment. I didn't want to prevent something important from being said, or make anyone feel uncomfortable. Today I just stayed outside when Mr. Kim had his enema. Somehow I felt he would be uncomfortable with me there too. Afterwards the nurse thanked me for being so tactful. The great thing is that being just outside the door I was still able to overhear the conversation and gather some important "observations" without being physically present in the room and distressing anyone.

As I complete this dissertation I see the value of the observation phase of my study. In my journal I wrote,

> I am so glad that I decided to include observations in data collection. The nurses couldn't always put into words what they were doing and why.... They couldn't tell me, but their actions showed me. Some of the data I have gathered through my eyes I couldn't have gained in any other way. The looks, tears, hugs, smiles, hesitations, playful touches, couldn't have been captured except on the film of the camera of my mind.

Levine (1987) advises that some things can only be learned by wading in slowly, from the direct experience of the ocean lapping against our bodies. The observational phase of my study allowed me this opportunity to wade in and experience the oncology world as the nurses were experiencing it.

Conversation. The interviews, or conversations, conducted can be characterized as open dialogues about the meaning of exceptional practice and each nurse's experiences in oncology nursing. To encourage the informal nature of these encounters they were held in places that the participants identified as most convenient and comfortable for them. Most of the conversations were tape-recorded with the permission of the nurses and the tapes were subsequently transcribed.

In the pilot phase of this project I entered practice interviews with a long list of focused questions. After two practice interviews, the question list gave way to a much more informal approach. This change was documented in my research journal.

> I just don't seem to be getting anywhere with my questions. The nurses answer them, but they appear to want to take me in different directions, tell me stories of their patients, share their experiences. Today one nurse said, "talking to you brings back some powerful memories," and I just went on asking my questions. I am upset with myself for insisting on my agenda. I just feel I am missing some of the really good stuff. Tomorrow I am going to just open with "Please tell me more about your experiences as a nurse?" and see what happens. I'm happy I discovered this problem early.

Leininger (1985a) supports the unstructured approach to interviewing. She said the open-ended manner unlocks the idea gate for people who need to be heard and allows them to tell their stories in their own style. "People like to tell, explain, and interpret their experiences in their own way without being interrupted with a host of questions...that may not be close to the informant's line of thinking" (Leininger, 1985a, p. 55). Polit and Hungler (1993) agree with Leininger and counsel that, "Imposing structure on the research situation by deciding in advance exactly what questions to ask...restricts the portion of the subject's experience that will be revealed" (p. 325).

I found the unstructured method resulted in long discussions filled with accounts of exceptional moments from the work lives of each nurse. Through their stories they freely shared their beliefs about oncology nursing, their feelings about what they do and why it is effective, and their attitudes about their work. As stated previously, these scheduled open-ended exchanges where supplemented with many additional spontaneous conversations.

Narrative exchange. According to Benner (1984) "Experienced nurses can readily bring to mind clinical situations that altered their approach to patient care. Through a systematic record and study of these paradigm cases, it is possible to extend the knowledge that is embedded there" (p. 9-10). Following the observation and conversation phases with the first six nurses I turned to collecting the nurses' written stories of their most memorable practice moments.

It was at this time that I contacted three additional potential study participants who had been recommended by the people at the study site. These nurses were from a variety of cancer institutions and cities in Canada. Two of the nurses contacted agreed to write their stories of exceptional practice moments for me.

During the data collection phase I had written in my journal my own memories of extraordinary patient care moments. As I wrote a letter to the study participants asking them to record their stories for me I became interested in the idea of narrative exchange, a written dialogue between the researcher and the participants.

> Today I had an interesting idea. What about talking to the nurses through my own stories? Sometimes hearing someone else's experience really triggers your own memory, and if someone is open with you it encourages openness in return. Maybe if I share my stories with them they will be able and willing to reciprocate. Also, if we are really in this together like I have said we are, exposing part of me may liberate part of them. This is more like doing research with them instead of on them or to them.

I offered each participant a letter and several of my narratives, suggesting that they too might have stories of exceptional practice moments they would be willing to share. In the letter I asked, "Who are the patients you still remember? Can you recall particular moments with them that were most important or satisfying, perhaps incidents that changed you or your practice?"

The response was varied. One nurse wrote about a single critical moment, while others wrote multiple pages about detailed intimate exchanges with their patients. They all offered striking examples of exceptional nursing practice. The knowledge revealed through the stories was contextualized and personal. Each story was unique, rich with its own cadence, style, personality, and wisdom.

As Ellis and Flaherty (1992) believe, research methods need to "shrink the distance" between the research participants and their experience. The writing of stories offers this opportunity. Ellis and Flaherty go on to say that, "writing stories is a conversation with self...and through this conversation we come to know ourselves" (1992, p. 6). Narrative exchange is a method that can make a lived experience understandable to self and others and a means by which this understanding can be communicated.

As the nurses wrote their stories many stated in notes or conversations with me how meaningful the writing experience was for them. In a card Marie wrote,

> I would like to thank you for asking me to share some of my memories. After reading your memories I wanted to begin to write immediately but I couldn't. My special moments were hard to retrieve. Many of them were difficult, some were sad, but all left a deep imprint on my perception and on the way I do things today. This was indeed a valuable exercise for me; like you, I relived some successes and some fears too, all of which have produced the nurse I am now. I feel truly blessed by what I have taken from these experiences; for what I've become because of them; and for what I have been able to do for others.

Another nurse Julie addressed these comments to me,

> I just want to say thanks for helping me open up a part of me that I could have shared in no other way but by writing my stories. There was something so liberating about sitting down with a blank page. I just sat and talked to the paper, and to you. The memories just came flooding back. Perhaps I've guarded them, protected them like keepsakes stored away in a secret hope chest. Now I'm so happy to have the chance to share them. It has helped me see the whole picture of my practice.

The use of observations, in-depth conversations, and narrative exchange as described was in keeping with the data gathering methods appropriate to both phenomenology and grounded theory. These channels produced abundant amounts of data to be analyzed and understood.

Data Analysis

In interpretive research, most times data gathering and analysis occur simultaneously in a spiral of increasing complexity rather than alone in a linear continuum. Parse, Coyne, and Smith (1985) write that, as one ascends through the various levels in the spiral, new dimensions of understanding are uncovered and new questions emerge which expand and support the findings. Werner and Schoepfle (1987), acknowledging that this is a lengthy process, conclude "interpretation can take a lifetime" (p. 16).

Polit and Hungler in their 1993 text-book on nursing research contend that, "There are no systematic, universally accepted rules for analyzing and presenting qualitative data" (p. 329); however, in approaching data analysis there were certain principles that I sought to uphold.

First, I wanted to be true to the nurses who participated. To me this meant including the context, and as much as possible using the nurses' words, giving them a chance to express themselves in their own voices. Consequently, I have used the nurses' stories and comments extensively throughout the reporting of findings. Following Benner's (1984) advice the materials have been left in the language they were delivered in. Care was taken not to fragment the experiences, at least in the hermeneutic analysis, because to do so would "distort that which it seeks to describe" (Anderson, 1991, p. 35). In most cases I left the nurses' stories intact. This allows knowledge to be revealed to the reader without forcing an interpretation.

Second, to be consistent with the philosophical basis of this study, data analysis incorporated the methods recommended by both phenomenologists and grounded theorists. A discussion of these methods of analysis follows.

Hermeneutic phenomenological analysis. There is no step-by-step method for analyzing phenomenological research data. As van Manen (1990) states, "The critical moments of inquiry are ultimately elusive to systematic explication. Identifying and communicating such moments may depend on the interpretive sensitivity, inventiveness, thoughtfulness, scholarly tact, and writing talent of the human science researcher" (p. 34).

The aim of phenomenological analysis is to "construct an animated, evocative description (text) of human actions, behaviors, intentions, and experiences as we meet them in the lifeworld" (van Manen, 1990, p. 18). It focuses on describing essential themes, "a thoughtful, reflective grasping of the special significance of this or that particular experience...bringing into nearness that which tends to be obscure" (van Manen, 1990, p. 32). Anderson (1991) summarizes, claiming the intent of phenomenology is "not to build grand theories of nursing but to understand the lived experience of people" (p. 36).

However, to discover the meaning of human experiences some analysis is necessary. Guidance as to how this discovery can be accomplished is provided by Oiler (1986). It is Oiler's "method" I chose to employ in this study.

Oiler (1986) suggests that analysis begins when the researcher reads all descriptions to obtain "a feel for them." During this reading, researchers attempt to hold in abeyance their presuppositions about the phenomena so that the phenomena can be seen as they are, not as they are reflected through preconceptions.

Next, from each source, significant statements and phrases are identified and meanings are formulated from these. The meanings are organized into themes which are displayed as a description of the experience. Uncovered themes provide the essence of the experience. To achieve validation, the researcher returns the descriptions to the participants for feedback.

Grounded theory analysis. Grounded theory analysis can include the use of three types of coding: open coding, selective coding, and axial coding (Strauss & Corbin, 1990). Each type of coding offers a different level of insight.

Open coding is the process of "examining, comparing, conceptualizing, and categorizing data.... It allows one to identify some categories and their properties" (Strauss & Corbin, 1990, p. 59). To accomplish this the researcher asks questions about the data and makes comparisons for similarities and differences between interactions or events. When similar interactions and events are identified they are given a label and grouped to form categories.

The second stage is axial coding. Axial coding involves "putting data back together in new ways...and making connections between categories" (Strauss & Corbin, 1990, p. 96).

Selective coding is used if the development of theory is the goal of the researcher. It is "the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development" (Strauss & Corbin, 1990, p. 142).

Chenitz and Swanson (1986) suggest that a basic level of grounded theory analysis can provide useful findings, although a more complex analysis may be necessary to reach the goal of theory development. For this study, open and axial codings were used to code and categorize materials by theme, and to investigate possible relationships between the themes. The limitations of this study did not permit the completion of selective coding, the bringing together of themes into an integrated whole, a "rich, tightly woven, explanatory theory that closely approximated the reality it represents" (Strauss & Corbin, 1990, p. 57). However, certain elements of selective coding, including the development of a story line and the identification of the core variable and its characteristics were completed. The grounded theory analysis was designed to show possible interrelationships of essences and themes and to take initial steps toward the goal of theory development.

Multi-dimensional analysis. Incorporating the recommendations of Oiler (1986), Strauss and Corbin (1990), and van Manen (1990) I designed a multi-dimensional analysis of the data. One analysis does not necessarily follow another in a step-by-step manner, rather each is important and somewhat independent of the others. While each analysis makes a significant contribution to the overall understanding of exceptionally competent nursing practice, one can appreciate an individual analysis for its own unique characteristics.

The first analysis was provided by the participants as they shared their memories and comments with me. They offered personal reflections and meaningful insights on their descriptions of events. As the nurses wrote their stories and talked to me they would often say, "What I learned from this was....", or "I think I did this to...." As the study progressed the nurses reflected on their own descriptions and actions, and shared these with me, thus providing me with additional understanding. To me this was valuable analysis provided by the participants themselves. These analytical comments are featured throughout this dissertation.

A second analysis was achieved by weaving together the stories, quotations from conversations, and field notes, arranged by themes, with the literature. This combination of what was seen and heard, with what has been published on the themes, provides the reader with an additional perspective.

A third component of understanding, the hermeneutical analysis, is reached through the poems featured primarily in the findings chapters. As a researcher reviewing the materials I thought carefully about the essence of each story or observation. To communicate this essence in a concise and meaningful way I wrote poetic interpretations. These are interspersed at critical points along with other channels of analysis.

From my perspective, the poem is a way of communicating meaning without imposing extensive structure on the data. I agree with Ellis and Flaherty who say, "While any literary form imprisons lived experience...without some form or structure, it would be impossible to convey any experience" (1992, p. 123). To me poetry provides succinct, yet dense, analysis. It is a means by which a researcher can communicate meaning received from the data. As van Manen suggests, poems are powerful means of sharing human experience because they do not require summaries. In his words, "The poem itself is the result.... To summarize a poem, to ask for the conclusion of it, would destroy the result.... The poem is the thing" (van Manen, 1990, p.

13).

I believe that poems are among the least invasive, and most effective means of hermeneutic analysis. They are able to communicate both the details and the emotion of the experience within the limitations of words, and they leave the reader with at least one possible understanding of the experience.

A fourth layer of understanding comes through analysis following the grounded theory method as described by Strauss and Corbin (1990). Field notes, transcribed interviews, and stories were reviewed systematically using the "constant comparative method." There was a search for the main themes and core variable and attempts were made to make connections between themes resulting in a beginning conceptual understanding of exceptional nursing practice.

The final dimension of analysis is left to the reader. By reviewing the words and stories of the participants and the analysis of the researcher readers will form their own insights about exceptional nursing practice hopefully making the analysis more complete. There were some stories and comments that were so powerful any analysis would have been superficial. Many of these were left in their as-told-to-me form and I invite readers to take from them what they will.

This multi-part account I feel is close to the nurses' realities. It is designed to catch and communicate as much as possible, including the sublime, unstructured, and non-verbal, and to reach the goal of increasing the reader's understanding of exceptionally competent nursing practice.

Trustworthiness of the Data and the Analysis

Interpretive research requires means for assuring standards of rigor that are different from those used in quantitative research studies. Because the purposes, goals, and intents of the two research paradigms are distinct from each other, different methods for maintaining data trustworthiness are advised for each type of investigation (Guba & Lincoln, 1982; Leininger, 1985a; Polit & Hungler, 1993). Despite their claims to the contrary, the alternative methods for maintaining "validity" and "reliability" of qualitative data purposed by Guba and Lincoln, 1982; Leininger, 1985a; and Polit and Hungler, 1993 remain noticeably similar to the methods used by quantitative researchers.

I believe that what the readers of this study need to know is what I did as a researcher that would increase their trust in my research ability and their confidence in the findings. Several actions were taken to ensure trustworthiness of the data and of the data analysis.

For example, during this study the nurses reviewed some of their own interview transcripts and field notes about them prior to the analysis phase. Written and verbal feedback and additional insights were offered by the nurses on these occasions. Two of the nurses reviewed drafts of the findings chapters and stated they believed the insights presented were representative of their experiences.

Additionally, each method of data collection served as an opportunity to supplement the others. During the interviews I was able to confirm my observations by sharing my views and asking the nurses for clarification and enhanced understanding. The narrative exchange provided a further opportunity to discuss the analysis of the data with the study participants as it was beginning to unfold.

During data collection I also had an opportunity to check my perceptions with the nurses on two occasions as I presented a preliminary analysis of the data to groups of health care providers. Following the presentations study nurses stated that I was "getting the real picture" and "seeing exactly what was going on." Corbin and Strauss (1990) confirm that, "seminars can give presenters confidence in their analysis whether preliminary or almost finished" (p. 235).

Providing data in context decreases the likelihood of misinterpretation. In most instances in this dissertation data are presented virtually unchanged allowing the readers to make some of their own interpretations. Tape-recording the interviews allowed for increased accuracy in documenting the words that were exchanged. I was able to transcribe the tapes and work from records of what was actually said.

Combining observations, interviews, and stories was effective because themes resurfaced and were expanded more fully through each process. For example, the written narrative accounts were similar in content and theme to the observations and the comments made during the interviews, giving me confidence that the themes highlighted were probably important.

In this study the credibility of the data was enhanced by prolonged engagement at the study site and by persistent observation. Data gathering for this study took place over a period of 14 months, from May, 1992 to June, 1993.

As I proceeded with this study, I kept careful records of the steps taken and decision points along the way. These comments were recorded in my research journal. Excerpts from this journal illustrating some of the decisions and changes made during the study are included in Chapter 2.

This study is not meant to be replicated in the quantitative tradition. It would be impossible to do so as I worked with a particular group of people in a unique situation. Other studies of exceptional oncology nurses would add to the body of knowledge about excellent nursing practice; however, this study was designed to stand alone in the distinctive contribution that it might make.

Self as a research instrument. There are many considerations related to the use of self as a research instrument and the influence on data trustworthiness. A major concern for me was my closeness to the area of study. Having been an oncology nurse for nine years the question arose of whether or not my personal experience would influence the quality of the study. The methods I chose required the use of self as research instrument, and I considered how this might affect the study.

Personal qualities of the researcher including interviewing and observational skills become influencing factors. Lipson (1991) adds that the quality of the data elicited is influenced by the informant's perception of the researcher. For example, the researcher's age, gender, culture, and profession may influence the amount, candidness, and honesty of the data.

In this study there was congruence between the researcher and the participants on most of these factors. As a result of my experience as a cancer nurse, I was familiar with the field of oncology nursing. Yet, because I had not worked at the study site and had not been in a clinical setting for some time, I was removed enough to be able to view it afresh.

Aguilar (1981) proposes that familiarity enhances ease of entry for the researcher. Krosha (1985) found this was true in her study of granny midwives. In this case, the researcher was a certified mid-wife herself which made it possible for her to relate closely to her informants in a short time. Aguilar (1981) adds that the common understanding of the language, procedures, and experiences can result in a more accurate account. My comfort level in the unit, and consequently my ability to relate in a relaxed manner with the staff and patients, was increased because I was familiar with the procedures, jargon, sights, smells, and grief associated with cancer.

There is similarity in the skills used in field research and those needed by nurses. Both use well-honed interviewing techniques, careful listening, astute observations, and interpretation on several levels simultaneously (Lipson, 1991). In this way my nursing experience helped prepare me to gather and interpret data accurately and thoughtfully.

Another consideration in the use of self as a research instrument involves the researcher's own personal style, issues, values, and biases. Aamodt (1991) writes that the researcher's own ideas will pervade the research whether the researcher wills it or not, so therefore the best approach is assessment and acknowledgement of self. Lipson (1991) observes that a beginning point is for the researcher to acknowledge these potential influences by describing his or her own background. This gives readers an understanding of where the researcher is "coming from" so they can make a judgement about the possible influence of the researcher's history. Lipson (1991) contends that, "The researcher's biases should not be considered a limitation as personal responses...can be capitalized on as a rich source of data and avenues of learning about a setting" (p. 76). In an attempt to reveal some of my possible biases and values, I have included in Chapter 3 a collection of my memories of working as an oncology nurse.

Aguilar (1981) emphasizes a critical consideration: the importance of the researcher's self awareness. She believes that lack of self awareness is probably to blame for some inaccuracies in interpretive data and their analysis. One interesting twist is that although self awareness is necessary for good field work, doing field work also helps develop self awareness as it brings researchers face-to-face with their own values.

Pilot Study

A two-step pilot study was undertaken to help prepare me for this project. The first step involved testing the interview questions on several cancer nurse associates from outside the study site. They critiqued the questions and my interview style. As described earlier in this chapter, it was at this point that I realized the long list of formal questions did not facilitate the acquisition of meaningful data and I abandoned the rigid and directed interview approach.

The second stage of the pilot study involved observing and interviewing two exceptional nurses at the research site. While many of the field notes and tape recordings from this experience were useful in increasing my understanding of exceptional nursing practice, I did change some proposed approaches to observation and analysis based on this second step in the pilot study. For example, it was at this time that I changed my research approach to focus on observation rather than participation.

The insights that I gained at this stage helped to direct my literature review on a more focussed course as some of the possible themes became evident. It also confirmed my belief that exceptional practice is a very complex phenomenon that cannot be forced into a simple linear model, or understood merely by reviewing qualities and attributes.

Assumptions

The assumptions of this study are compatible with the philosophies of phenomenology and symbolic interactionism. It is assumed that meaning is a central concept in that it mediates human interactions. People are not merely reactive organisms; rather, they think about and are deliberate in their actions.

I assume that what the nurses shared with me are their honest perspectives. Acknowledging the existence of multiple realities, I retain the belief that from their perspectives they shared with me their own understandings.

I based my method on the assumption that interpretive research remains in a developmental stage. There is debate over the proper techniques and methods for data collection and analysis even within specific philosophies. I have taken into account the various opinions regarding the appropriate steps to be followed, but I have allowed myself room to explore and bend the rules in an attempt to enlarge upon how we currently see and do interpretive research.

Finally, I assume that the essence or core variable of a phenomenon can be understood and described, and indeed that there is such an entity as exceptional oncology nursing practice.

Delimitations and Limitations

One important boundary for this study is its focus on nurses who specialize in oncology nursing. This can be viewed as a strength in that it concentrates the research on an in-depth investigation of this group.

A further delimitation is related to the number of respondents. As described previously, I settled on a sample of eight nurses. Perhaps it would have strengthened this study had I spent more time with each nurse. Optimally I would have chosen to spend a longer time listening to, observing, and sharing stories with the participants. Although the literature on qualitative research counsels that the researcher may conclude data gathering once the point of "data saturation" is reached, I am not convinced that saturation ever occurs. Within this particular study environment there were many components to each interaction and the elements were constantly changing and rearranging. As long as I was exposed to the nurses who were meeting new patients daily, I was gaining enhanced, or perhaps even new, understandings. However, given the reality that this study did one day have to come to an end, data gathering in the formal sense was drawn to a halt. For me, however, this study will continue for some time.

One final comment - I realize there will always be explanations and ways of viewing these data other than those put forward in the analysis sections of this document. I, as researcher, am limited by my cognitive make-up, by my abilities to perceive and to grasp the meaning of the experiences observed and discussed. I invite you, the reader, to take what I have offered and to go beyond what I have done, to venture alternative analyses of the data, thereby rendering this limitation less consequential.

Ethical Considerations

I believe that this research method carries with it many ethical considerations as I entered the nurses' world and sought to discover and report personal and intimate thoughts and experiences. It was a privilege that I made every effort not to abuse.

The fundamental ethical principle guiding this research with human beings was that of beneficence, which encompasses the maxim: Above all, do no harm (Polit & Hungler, 1993, p. 361). With this in mind I structured my design with the objective that no one concerned would be harmed, or exploited, and so the potential benefits of doing and participating in the study would outweigh any risks.

The informants and I discussed the possibility that participation in the study could change them and the way they give service. We anticipated the possibility that reliving their meaningful nursing moments coupled with introspection might result in some personal distress for the participants. To temper the potential harmful affects of this I allowed sufficient time to talk and to debrief the nurses, which was designed to enhance the positive consequences of this part of the process.

I was careful not to exploit the nurses' time by asking for too much. If I sensed that they needed privacy I spent time in the unit alone with my field notes, or asked to spend just part of a shift with the participant.

After discussion with some potential study participants we concluded that the benefits of participating in and completing this study outweighed the risks. The knowledge to be gained was seen to have potential utility for many people. To the participants themselves, the potential for increased self-knowledge, enhanced self-esteem, and the excitement of being part of the study were all considered to be positive outcomes of the project.

Ethical approval to proceed with the study was obtained from the Department of Educational Administration at the University of Alberta and from the research committee of the study hospital. All participants in the study signed an informed consent form (Appendix B) indicating they understood the nature of their participation in the study. Being cognizant of the nurses' rights to self-determination, this consent assured the informants that participation was voluntary, that clarification could be sought at any time, and that withdrawal from the study would be without penalty.

Though I included the written consent in my effort to be ethical, I continue to question the value of these documents. The nurses had no way of anticipating in advance of their participation what I would see or what they would share. Perhaps a consent signed by participants after studies of this type are completed would have more value.

All data collected and drafts of this dissertation are maintained in confidence in a locked drawer in my home. A second copy of all materials exists in a secured location in the home of a friend. The names of all informants, patients, and locations have been changed for this report.

While confidentiality has been carefully guarded, total anonymity was not possible. The nurses who participated are known to each other and to me. I can link each participant with data associated with that participant. However, to facilitate anonymity to some extent all examples have not been attributed to a specific respondent. Rather, sometimes comments, observations, and stories have been interwoven to provide an integrated picture of exceptional nursing practice.

I spent time preparing myself for field research, anticipating possible ethical situations that could arise and formulating what I thought would be feasible responses to such situations. What would I do if I saw a nurse providing what I considered unsafe care? How would I respond if a patient in need asked me for help? What would my response be if a nurse I was observing asked for my assistance or advice? By talking with the participants openly about my role before beginning the study, these occasions were minimal. My observer-as-participant stance also reduced the occurrence of these situations and minimized my influence on the interactions.

I also deliberated about how much I should disclose to the informants about myself. My concern was that it was unjust to ask the nurses to share so much about themselves with me, without disclosing something of my situation. Where was the point where sharing my own stories would increase the connection and therefore candidness and depth of the interviews and narrative exchanges, and where would it interfere? Following the advice of Young and Tardif (1992) I intentionally shared some of my own related experiences at an appropriate moment in each relationship. In most instances this moment was during the conversations and as we began the narrative exchange.

Another ethical issue for me was the need to be true to the nurses in the study, to record, interpret, and convey their feelings, thoughts, and actions accurately. I believe that through ongoing verification with the nurses the accuracy was maintained. Reporting the findings, at least for the most part, in their own words also increased my confidence. In all instances I gave the nurses the authority to withhold any particular comment, story, or observation from the dissertation.

Finally, I deliberated whether ethically I have the right to attempt to capture, understand, and communicate to others something as complex as human behavior and thoughts. Will any attempt to discuss, describe, or report such behavior and thinking be so simplistic that an injustice is done?

I anticipate that a variety of people, including nurses and others working in human service fields can benefit from the findings of this study. Although my attempts to unravel the intricacies of exceptionally competent nursing practice and transpose my understandings into words can be at best limited, I believe it is worthwhile to try.

CHAPTER SUMMARY

Chapter 2 described the design of the research study. A discussion of the two qualitative methods used, grounded theory and hermeneutic phenomenology, was central to this chapter. Specific details about the study participants, channels of data gathering, and data analysis were discussed. Techniques for maintaining data trustworthiness, the pilot study, the assumptions made, the delimitations and limitations of the study, and a discussion of ethical considerations were also featured.

To facilitate understanding the findings, the reader may benefit from supplemental insight into the context of oncology nursing. Chapters 3 and 4 provide some of this background.

Chapter 3

LANDSCAPE SCENE I: ONCOLOGY NURSING

CHAPTER INTRODUCTION

The purpose of this chapter is to establish part of a contextual basis, a landscape against which a description of exceptional nursing practice can be clearly viewed. As a preamble, a brief review of the literature on the nature of oncology nursing is presented. Statements from conversations with unusually competent nurses are highlighted in a discussion of some particular features of cancer, the disease of primary interest to oncology nurses.

This landscape also includes a collection of my memories, stories from my experience as an oncology nurse. By sharing these vignettes I hope to convey something of my values, beliefs, and possible biases. I realize that "researchers who write about their own emotions risk being seen by colleagues as emotional exhibitionists" (Ellis & Flaherty, 1992, p. 3). However, I believe that allowing readers to incorporate an understanding of my experiences into their own stock of knowledge will increase their general understanding of me, of oncology nursing, and ultimately of exceptional nursing practice.

ONCOLOGY NURSING

Nursing has been acknowledged in the literature as both a demanding and rewarding profession (Arcand, 1980; Benner & Wrubel, 1989; & Marshall, 1980). An essential feature of nursing is that it is an experience lived between human beings, primarily between patients and nurses. A therapeutic, goal-oriented process, nursing service is directed at meeting patient needs. These needs may be physical, psychological, intellectual, or spiritual in nature and will differ with varying health problems (Samarel, 1991).

Nurses often hold the fragility of human life in their hands as part of their everyday work life. Nurses routinely administer complex treatments that allow for a very small margin of error. The knowledge explosion in health care has resulted in the increased use of technology, and further complication of treatment protocols. Among the responsibilities assumed by nurses are the promotion and restoration of health, prevention of illness, attainment of a peaceful death, and maintenance of a therapeutic environment in which these goals may be achieved.

As a first line of defense and advocacy for the patient, the nurse is in a position of privilege and responsibility. This responsibility necessitates establishing and maintaining relationships with multiple professional groups. Nurses working a variety of shifts provide nursing services to patients 24 hours a day. Arcand (1980) in her study of stress and oncology nursing states that these considerations can make nursing physically and emotionally exhausting.

Fagin and Diers (1983) assert that,

> Nursing is a metaphor for intimacy. Nurses are involved in the most private aspects of people's lives and they cannot hide behind technology or a veil of omniscience as other practitioners...in hospitals do. Nurses do for others publicly what healthier persons do for themselves behind closed doors. Nurses are there to hear secrets, especially the ones born of vulnerability.

Benner and Wrubel (1989) contend that those who choose to be nurses can expect frustration, despair, highs, lows, and defeats often enough to remain humble. Yet, as Peplau (1952) concluded over a century earlier, nursing can be a maturing force and an educative instrument. Mallison (1987) expresses it this way,

> If you keep working at it, learning from it...gradually you realize your palette is filling up with colors. You see more shades of meaning. You realize you are well on your way to creating a work of art, maybe even a masterpiece. (p. 45)

Oncology or cancer nursing is a specific form of medical-surgical nursing. Nurses who specialize in oncology provide nursing services to people who have cancer throughout the stages of the disease. This specialty is unique for many reasons.

First, cancer is a very common and serious disease. In 1988 it was the second leading cause of death in Canadian adults (World Almanac, 1990). The prevalence of cancer means that most oncology nurses have had a personal association with the disease through family or friends. Some nurses have been treated for cancer themselves.

Second, the treatment of cancer is usually a lengthy process, often causing disruption in the work and family life of the patient. These disruptions, combined with the plaguing side-effects of the therapies, place demands on the patient, the patient's family, and the care-givers. Highfield (1992) writes,

> A diagnosis of cancer often provokes a crisis of meaning. Personal relationships may be burdened with an uncertain future. Formerly effective coping strategies seem inadequate...there is a rising sense of aloneness. In short, a spiritual crisis is created. (p. 1)

Third, the guilt associated with having cancer adds to the suffering of the patients and their families. Julie, one of the nurses I observed, phrased it like this,

> Though the etiologies of many cancers are unproven, a diagnosis of cancer is often accompanied by guilt. There is a whole school of thought out there that projects to the vulnerable, grieving, cancer patient that this whole disease is their fault. Comments like, "You can fight this thing," or "With the proper attitude it can be overcome," make them feel responsible both for getting sick and for getting well. There probably is someone somewhere who drank a herbal tea, prayed in a certain position, ate peach pits, or laughed themselves into being reportedly free of cancer. But it makes the remaining millions feel abjectly guilty, as if they have done something wrong.

Fourth, cancer is culturally among the most dreaded diseases. One of the most frightening sentences a person might hear is, "You have cancer." These words bring a chill to the heart. Although some progress has been made in treating cancer, recovery can be long and painful and many people do not survive. Its chronicity and close association with death and suffering make it a somewhat taboo topic in our society (Benner & Wrubel, 1989, p. 267).

According to Benner and Wrubel (1989),

> In society the disease cancer appears to have become the metaphor for the deepest fears held about the inevitable disintegration and decay of the body. Cancer is the disease which attacks the body organs about which greatest ambivalences are felt, those of sexuality, reproduction, and excretion. The society "battle" against cancer is then seen as the struggle to resist acceptance of the inevitability in life of death, decay, and decomposition. (p. 8)

Glaser and Strauss (1968), after extensive study of cancer care settings, conclude that the trajectory toward death is often more difficult for care-givers and survivors than for patients. Benner and Wrubel (1989) agree that providing nursing service for cancer patients is especially challenging because nurses need to "adopt ingenious strategies for providing comfort, nutrition, social support, rest, and activity in the midst of demanding treatment regimes and a debilitating disease" (p. 256).

Julie summarized her view of the devastating nature of cancer in the following comment.

> We must realize that cancer is relentless and shows absolutely no respect for its host. Cancer writes its own rules. It teases, in fact, each remission gives a little taste of hope for normalcy. Then, there is the emotional murder of recurrence, just to reassure patients that they are at the mercy of this monster and needn't begin to think otherwise.

MY MEMORIES

I am a nurse. Although I am not actively practicing nursing, I still approach life as a nurse. I like to say that I have the conscience of a nurse. From a very young age I was "nurse" to my family, friends, and pets. In college I was advised that nursing was a "fine career for a young lady" and as this advice was strongly supported by my early encounters, a nurse I became.

Upon graduation I was offered a position providing nursing care to people with cancer. I accepted, but entered this very foreign and frightening world with much trepidation. Would I be able to bear the sights, the pain, the emotion? At first the temptation to run was great, but fleeing meant failure so I stayed and practiced cancer nursing for nine years.

Entering a hospital to begin my data collection after being away studying for two years filled me with a myriad of feelings. I was comfortable at once, as if I were among friends though I had never met any of the patients and few of the nurses who worked on the study ward. It was like revisiting a familiar place even though I had never been there before.

Yet, as I began my observations I found myself feeling the emotions of each moment more intensely than I remembered in the past. I came home from data gathering feeling very tired and emotionally in a turmoil. Faces, names, and moments with special patients from my years of nursing bombarded me. Often, without warning, I would discover myself in another world, at another time, reliving those past encounters. Some recollections were especially intense, others more mundane; but all were important to me.

The significance of these flashbacks was supported by Julie who wrote this paragraph as a preface to her recollections of her most unforgettable nursing moments.

MOMENTS IN TIME

> Each of us is a collection of significant moments. If life could be distilled down to one hour in time, that hour would include a cluster of significant moments. A moment is that which recurs when needed; it is that recurrence which magnifies the significance. These moments fill our memory banks. They are our resource files, our warm fuzzies, the emotional adhesive that holds us together. They are us.

My research journal became the recipient of my memories. As I wrote about my patients my mind cleared and my resolve to complete this research became stronger. My observations of the nurses became less clouded with my own remembrances and I became more focused on the current situation.

I believe that these recollections have a place in my dissertation. I want to share something of myself with you and I feel these memories of my nursing life are one way to fulfill this objective. By including these stories I am not claiming that I am, or was, an exceptional practitioner. My purpose instead is to provide a small number of my more potent memories from my experience as an oncology nurse, thereby imparting some understanding of this experience and of me.

The Day I Became a Nurse

> She was so ill. She was bleeding to death in front of my eyes and there was little I, or anyone could do. As I helped her back to bed her three beautiful teen-age sons pressed closer to the wall and watched in horror. Not knowing how to help her, I sat down on her bed and took her hand tightly in mine. Putting aside all thoughts of the half dozen other patients who needed me, I let my energy flow into her.

As silent seconds passed I felt some of her spirit pour into me. At that moment I was changed. At that moment I became a nurse.

The Bald Man with the Big Laugh

I had just been appointed chemotherapy nurse, a position I assumed with much pride and enthusiasm. The emphasis of my duties now would be on teaching the patients about the drugs they were to receive, something I really enjoyed doing.

As with any new responsibility, there was a certain amount of anxiety at first and I was shaking a little as I approached Mr. and Mrs. Zimmerman to teach them about Mr. Zimmerman's chemotherapy. However, I was determined to do well and I had a sophisticated teaching plan, complete with objectives, in hand. Sitting down I launched into my lecture about the side-effects of the drug he was to receive, the major one in his case being anticipated hair loss. At one point in my monologue I realized that both Mr. and Mrs. Zimmerman were looking at me with some amusement. Pausing long enough to assess the situation, I realized to my embarrassment that Mr. Zimmerman was already totally bald and had been for many years as a result of natural causes. I stopped speaking, stammered a little and then we all burst into a cleansing round of laughter, laughter that swelled until the tears came.

On Melting Anger

She was such a gruff woman. My most vivid memories of her revolve around her sitting upright in her bed issuing caustic commands to her family members and care-givers.

Being a novice nurse who was eager to please I was succulent prey for her and she was crude, harsh and cutting in her demands of me. "Move that water jug," "fluff my pillow," "bring me juice," she would snap. Often I was afraid to answer her call bell and face her anger. Yet as the days went on I started to like her. I looked forward to seeing her and being her nurse.

One day in response to her demand that I "help her out of bed, NOW," I put my arm around her shoulders to offer her support. "What are you doing?" she barked. As our eyes met I said, "I'm just trying to help you, I want you to be as comfortable as possible and I don't want you to fall and hurt yourself." She muttered a muted "Oh" but at the same time, as I held her emaciated frame tightly I felt some of her muscles relax just a little and I knew that I had touched her with my touch.

It Was a Good Death

The warm amber glow of a candle filters through the quiet air. In the bed covered with a patchwork quilt that she has made a middle-aged woman breaths shallow, erratic last breaths. Her husband of a quarter-century sits at her side brushing her cheeks with his stocky fingers and with occasional soft kisses. Although she is unable to talk, he tells her how much their life together has meant to him and how much he will miss her. As her breathing ceases he gives her a final kiss and turns to me. Freely, I open my arms and my heart to him in his grief. I leave them alone for a moment to say good-bye. As I go, he says, "Thank-you." I smile inside, feeling privileged to have shared in the final moments of their life together.

Mama Goes to Heaven

The soft strains of music touch me as I enter her room. Around the bed hand-in-hand stand her eight children. My patient is a recently immigrated Italian woman of 60 years. Her life is nearly ended, and pain remains her greatest adversary. No amount of analgesic has soothed the relentless agony. Quietly, her family begins to work magic. As they sing softly in their native tongue my patient dozes in peace. They take turns, sometimes singing joyously in unison, other times a sweet sad solo voice is heard. As they sing she slowly slips away. They each say good-bye to their "Mama" and then move on to live the rest of their now more precious lives. After they have gone I say my own farewell to this brave lady and I feel honored to have helped escort her to peaceful rest.

Learning the Value of Honesty

Being so young, she quickly became everyone's favorite patient. As I enter her room she sits on her bed cross-legged, neon clad, and hugging a huge stuffed elephant. For several seconds I stare at her, struck again by the incongruence of the child-like face so clouded by the haggard expression of one who has experienced the stress of chronic terminal illness. As I sit down beside this child she looks at me and asks with penetrating frankness, "Am I going to die?" In the time-less seconds that follow my mind races, searching frantically for an answer and rejecting all the possibilities. Finally, my lips open and as honestly and gently as I can I say "yes." I know my eyes filled with tears first as we dissolved into one another's arms, grasping for the comfort of human touch. How utterly important she was to me at that moment, and how vital I was to her.

The Secret Whispers

"I miss them so much," she sighed as I washed her back and tried to make her more comfortable. "I haven't seen my kids for nearly a month. I would give anything to give them a hug." I touched her hand and as our eyes met I knew I had to help her.

Two days later it happened. Three pre-schoolers climbed onto their Mom's bed and blanketed her in hugs, kisses, and cookie crumbs. It was such a joyous afternoon. As they leave her to return home she plants a secret whisper in each small ear, a whisper of her exclusive love for each of them.

Later that week as we struggle to save her fragile life she opens her dying eyes just long enough to tell me a secret. "Please let me go," she whispers, "I'm ready." As we withdraw the life-support equipment I am overcome with feelings of peace and achievement. We have given her the greatest gifts possible for her, secret moments with her children, and death with dignity.

Silent Music

In report they announce that I am to give one-to-one care to a young woman with leukemia. She is distressed and agitated because of recent news that her disease is out of remission. Knowing that I will be her constant companion for the next eight hours I try to think carefully about the approach I will take in our conversation. What should I say? How can I let her know that what she is feeling is normal? What can I do to offer her the support I know she needs?

As I enter her room I am still unsure of my opening words, so I say nothing. Sitting close to her on her bed I take her cold hand in mine. Softly stroking her forehead I speak only with my eyes and touch. She seems relieved and I can feel the tension ease. The silence, it appears, is a welcomed friend. It feels tranquil. Nothing is frantic, nothing needs to be said. It is as if the agony and strain have been replaced by music that we can both hear.

My Reason for Caring

"Here is your patient for today." As I get off the elevator, I look up to the voice of my charge nurse. She is holding a tiny baby wrapped in a hospital blanket and she is handing the babe to me. Involuntarily, my head is shaking no, while inside I struggled to confirm what is happening. A baby - with cancer - my

> patient? It just can't be.
>
> But it is true. As she transfers the wee infant to my arms I recognize the unmistakable look of the disease etched on the little face. She is swollen from the medications and her bald head carries the bruises and scars of repeated intravenous insertions. The grey-yellow complexion of death is indisputable.
>
> That intense encounter with the brutal injustice of cancer followed me throughout my career. Occasionally, I wonder how I kept going, how I kept caring. Much of my motivation came from a tiny pendant given to me by a friend. I wore it always. Once in a while I would catch a glimpse of it in a mirror as I gave my patients care. "Live-love-laugh," was its message. Whenever I saw it, I knew I must carry on, for my sake, for the sake of that innocent child, and for the patients I was yet to meet.

As I relive these events from my nursing years I recall that the anguish was often great. However, through these same experiences came a sense of achievement and the knowledge that I was making a difference in the lives of others. For me cancer nursing was an incredible opportunity, a chance to be intimately involved with people who were entering one of the most critical times of their lives.

What a privilege it was to encounter the humanness of life as part of my everyday work life. I feel that I have been shaped by my experiences with cancer patients and their families. Seeing others bravely facing their disease, their treatments, and their uncertain futures helped me realize how precious and precarious life is. As a result of these experiences my life became brighter and more full of texture. Personal relationships were enriched and life took on a strange combination of urgency on one hand, and relaxed animation on the other. I was inspired to laugh liberally, cry openly, care deeply, and study intently while at the same time savoring every second of each experience.

Through reflection on my own involvement as I nurse I have also come to realize that nursing is very complex and multi-faceted. Our understanding of the actions and thoughts of those nurses who do it exceptionally well remains limited. I feel certain that studying the ways of those nurses who provide nursing service with unusual competence can enhance our awareness and appreciation of excellent practice.

CHAPTER SUMMARY

The objective of Chapter 3 was to provide readers with a beginning appreciation of the context of oncology nursing. This was done in part by a brief review of the literature on the nature of oncology nursing. In addition, some of the study nurses' comments regarding cancer were presented. Finally, I shared some of my experiences as an oncology nurse to provide readers with a glimpse of my values, beliefs, and biases regarding oncology nursing.

Before proceeding with specific illustrations of the approaches used by the nurses studied, a discussion of the philosophies of these nurses will add to the landscape against which the research findings can be more plainly viewed. This component is provided in Chapter 4 where the philosophies of the exceptionally competent nurses are compared with those of selected nurse theorists.

Chapter 4

LANDSCAPE SCENE II: A COMPARISON OF PHILOSOPHIES

CHAPTER INTRODUCTION

This chapter adds to the contextual basis of the research. Its purpose is to provide additional information needed to facilitate understanding of the findings of the study. In the chapter key components of selected models of nursing (predominantly those proposed by Leininger, Watson, Parse, Paterson and Zderad, and Benner and Wrubel) are reviewed and compared to the views articulated by the exceptionally competent nurses. Each theorist's espoused beliefs regarding five key elements of nursing practice, namely, the nature of health, human beings, nurse-patient relationships, nursing, and the nursing milieu are highlighted.

The views of the exceptionally competent nurses present some contrast to the thinking of these major theorists. A composite picture of their beliefs regarding the same five key elements provides a glimpse of their unique perspective. In addition, the nurses studied have well articulated ideas regarding the nature of self, and life and death. These views, which in most instances go beyond the scope of the theories articulated in the literature, are also explored in this chapter.

In summary, the contextual basis for this dissertation is formed in part by the illustrations and comments regarding oncology nursing from Chapter 3. These, combined with a review and comparison of selected nursing philosophies, and a sketch of the exceptional nurse's espoused beliefs about elements of nursing, provides the landscape against which the findings can be understood.

PHILOSOPHIES OF NURSING

Most nurses hold a clearly articulated set of beliefs about nursing and nursing practice. They have an attitude toward life and reality that emanates from each their beliefs and values (Bigge, 1982). This philosophy motivates actions, guides thinking, and influences decisions (Bennett & Foster, 1990, p. 167).

Nurses express their philosophies through their ways of nursing (Wiedenbach, 1964). A nurse's beliefs and values about the significance of life, the worth of the individual, and the aspirations of each human being determine the quality of nursing care given (Wiedenbach, 1964, p. 7). As Samarel (1991) succinctly proclaims, "How one performs as a nurse depends upon one's philosophy" (p. 72). Kikuchi (1992) agrees indicating that our underlying philosophies give important direction to our lives and our ways of practicing nursing.

This belief is congruent with the interactionist perspective which holds that our responses and behaviors are based upon our interpretation of others' acts. These interpretations are in turn dependent upon our personal philosophy and value system. Ways of being, one's values and beliefs, shape one's ways of doing. To be is to do from the interactionist viewpoint. As Bennett and Foster (1990) state, "philosophy underlies purpose and purpose reflects philosophy" (p. 13). Following this line of thinking, the philosophies of the nurses studied become a critical component in a thorough investigation of exceptional practice.

Bennett and Foster (1990) propose that a philosophy is personal in character and unique to each nurse (p. 167). While no two people share exactly the same beliefs and values, among the nurses I studied there were some commonalities in their views of the nature of the nursing milieu, human beings, nurse-patient relationships, nursing, health, self, and life and death that I believe provide a collective philosophical basis from which these nurses practice.

Although the expressed values and philosophies of the participant nurses - in keeping with the contributions of Bennett and Foster - were not identical, the similarities are striking. This finding was not central to the focus of this study, and therefore its genesis was not pursued. It seemed sufficient to examine the philosophies of the exceptional nurses and compare them to those articulated in the literature.

However, the common philosophy does raise questions for future investigation. For example, did the kindred values and beliefs arise from professional or work place socialization or acculturation? Perhaps a strong nurse-to-nurse bonding in a stressful work environment resulted in a sharing of values that gradually caused them to share a similar philosophy of nursing? Did they hold these values and beliefs before choosing oncology nursing, or were their philosophies shaped primarily as a result of their experiences with cancer patients? Alternatively, this shared philosophy may be the result of the specialized context in which the nurses practice, combined with their exceptional abilities. Perhaps to flourish and become exceptional in an environment where all patients face their mortality, a nurse must begin to see the world differently.

Several nurse theorists have espoused theories that incorporate descriptions of their beliefs about the nature of nursing, health, the nursing milieu, the nurse-patient relationship, and human beings. Nurse scholars who have critiqued these works suggest that many of these "theories" are actually philosophies of nursing (Uys, 1987; Sarter, 1993).

I chose several theories or philosophies and compared the writers' views on the five key elements identified. The theorists selected for inclusion, in my opinion, hold paradigms that are consistent with the philosophical standpoint of this study. Following a comparison between theorists, the beliefs of the exceptional nurses on each of these elements is reviewed and contrasted with the perspectives provided in the literature. As suggested earlier, the exceptional nurses often held a more comprehensive set of beliefs than those detailed in the literature and provided new ways of seeing the world.

The nurses shared their beliefs directly during conversations, and indirectly through their stories and actions. Samarel (1991) confirmed that "values are expressed overtly through verbalization and covertly through behavior" (p. 72).

The Nurse Theorists' Views on Health

The nature of health is one of the key elements described in most of the nursing theories reviewed. Parse (1981), Watson (1985), Leininger (1985b), Benner and Wrubel (1989), and Paterson and Zderad (1976) all directly state their views regarding health.

Leininger emphasizes the role of culture in health. To Leininger (1985b) health is a "state of well-being that is culturally defined, valued, and practiced which reflects the ability of individuals or groups to perform their daily role activities in a culturally satisfactory way" (p. 156).

For Paterson and Zderad (1976) health goes beyond Leininger's emphasis on well-being to include a state of "more-being" the process of becoming all that is humanly possible. Health is more than the absence of disease; it is a process of finding meaning in life (Paterson & Zderad, 1976). These theorists claim that when we relate authentically with each other, and uncover significance in life, we experience health.

Like Paterson and Zderad, Parse (1981) defines health broadly. For her health is a process of participation with the world, a synthesis of values, and a way of living. According to a review by a nurse scholar Sarter (1993), Parse does not make a clear distinction between health and illness or disease and non-disease but she does view health and illness as non-dichotomous.

For Parse (1981) health results when a person becomes more diverse and complex, achieving a synthesis and harmony of mind and body. Since health is a goal of both the diseased and the well, Parse emphasizes that it is important for the nurses, as well as patients, to achieve health.

Benner and Wrubel (1989) contribute to the definition of health, making a clear distinction between illness and disease. They claim that, "illness is the human experience of loss or dysfunction, whereas disease is the manifestation of aberration at the tissue, cellular, or organ levels" (p. xii). For them health is more than the absence of disease, it is also the absence of illness.

In a similar way Watson (1985) also distinguishes between disease and illness. She suggests that a disease might be cured but illness would remain without caring. Even if the disease is overcome, health is not attained unless the person has been cared for. She maintains a person can have health without the absence of disease if there are efforts underway that will lead to its cure.

According to Watson, health is the overall physical, mental, and social functioning achieved when the body, mind, and soul are in harmony. On a more conceptual level, she holds that health is congruence between self as perceived and self as experienced.

In summary, the predominant view of health provided by these theorists is that it is more than the absence of a disease process in the body. A person is not seen to have health unless there is an absence of illness as well as disease. Views on how that health state is achieved vary among these theorists.

The Exceptional Nurses' Views on Health

Collectively, the exceptionally competent nurses studied reject the view that disease necessarily makes a person unhealthy. To them a patient can have the disease, cancer, and still have health. Lana, one of the participating nurses, said, "Patients can be healed though they are not physically well."

Some of the nurses studied believe that disease can lead to health. They cite examples of individuals who, by their own definition, led meaningless, unhappy lives before they were diagnosed with cancer. These same individuals, after being diagnosed with cancer, became more fulfilled, happy, and "healthy" people even if their disease was not cured. Maureen reported,

> Many of my patients say they appreciate the little things in life a lot more since they got cancer. One man told me that though he lost his job when he got

sick, he regained his family, and his life.

Another nurse participating in the study, Jane, told me this story about one of her patients.

> This patient I remember, I remember her because of her pain. It was bad, really bad, but she was amazing. She was a really tough person. From her stories I think she had seen it all, been a hooker, drugs, everything. She had cervical cancer that had spread extensively. Even though she was in pain and supposed to be in bed, I'd always find her up helping some other patient with their blanket or their water or she'd just sit beside them and comfort them. I think having cancer really changed her. She told me it made her a person she never thought she could be.

The nurses emphasized that patients have different levels of wellness. Some have spiritual and emotional health, while physically they are very ill. Like Watson (1985), they see complete health occurring when all components of self are as healthy as possible.

This harmony, or complete health, can occur without being free of disease, if patients are helped to fulfill their potential within the limitations of their current circumstances. Even those who are dying, and therefore are physically compromised, can be physically healthy if their bodies are reaching their potential. Julie said,

> We have to be realistic here, but we can help patients do as much as they can do. Maybe they can't go home to stay, but they might be able to go on a pass for a few hours. Maybe they can't walk, but they could get out of bed and sit up in a chair. We have to help them do all that they can.

For these nurses, if their patients are able to do all that they are capable of doing, they have helped them achieve health. Complete health is considered a complex interrelationship of physical, emotional, and spiritual well-being. Health, in the view of the exceptional nurses, can be attained without the absence of disease.

The Theorists' Views on Human Beings

Nursing is an experience that focuses primarily on interpersonal contacts between nurse and patient. Within this dyad, the nurses' beliefs about the nature of human beings potentially has a great influence on these interpersonal encounters. Most of the nurse theorists expressed views related to the nature of human beings. These views are central to their theories of nursing.

For example, Leininger (1985b) views human beings as caring and capable of being concerned about the needs, well-being, and survival of others. She states that the capacity to care is universal to humans in all cultures.

Like Leininger, Watson (1985) also focuses on the theme of care. She says human beings have value and are to be cared for, respected, understood, nurtured, and assisted. In her view, all individuals strive to fulfill their potential and meet their needs. Watson believes people have a need to belong and a need for affection manifested in a need to love and be loved.

According to a review by Sarter (1993), Watson is the only nursing theorist who explicitly supports the concept of soul and emphasizes the spiritual dimension of humans (p. 152). For Watson the soul is the most powerful force in human existence, being the source of each individual's innate striving toward self-transcendence or actualization of one's spiritual essence. In Watson's estimation, the basic inner striving of each person is to fulfill one's evolutionary potential.

Paterson and Zderad (1976) share the reverence for life alluded to by Watson and Leininger. They believe in the value of human interaction, claiming it is through relationships that humans become actualized. These scholars suggest that we are all involved in a similar search for meaning in life (p. 280). Though our quest is similar, people are believed to experience the world uniquely in Paterson and Zderad's model of nursing.

In their discussion of the nature of human beings Paterson and Zderad (1976) emphasize freedom of choice. They believe people are capable and have the capacity to choose. The choices made determine the direction and meaning of a person's life.

Consistent with Paterson and Zderad, Benner and Wrubel (1989) also present a phenomenological view of the individual. They describe a human as a "self-interpreting being" that is, "the person does not come into the world predefined but becomes defined in the course of living a life" (p. 41).

As expected, meaning is important in the Benner and Wrubel (1989) view of human beings. They suggest that people understand a situation in terms of its meaning for them and they stress the belief that people can care, and that as a result of caring humans become involved with others.

Benner and Wrubel (1989) also address the nature of human beings in their discussion of mind and body. They claim that "mind and body are not dual entities.... The mind is both constituted by, and constitutes, the body. The influence between mind and body is synergistic and mutual" (p. xii).

In summary, the writings of all nurse theorists reviewed portray a reverence for life and the inherent value of a human being. Several state the view that humans are naturally caring beings who express that caring through concern for the well-being of others. People are seen to have needs, and for those theorists who theorize from a phenomenological perspective, the fundamental need is to find meaning. Most of the nurse theorists articulate the view that humans are capable of choosing and should have that freedom. This has implications for the nature of the nurse-patient relationship to be discussed in the next section. Watson (1985) made a unique contribution with her discussion of the existence of a soul.

The Exceptional Nurses' Views on Human Beings

Like the nurse theorists reviewed, the exceptionally competent nurses hold a respect for life and value each individual. Mindy wrote,

> We are all human. We are all in this world together. We all share a common fate as one day we will all die. Everyone has value and deserves the best care we can give and everyone deserves to have that care given with compassion and dignity.

During one observation period Moria, the nurse I was watching, was caring for a man who was experiencing alcohol withdrawal. In addition to his cancer, he was a chronic substance abuser and had lived most of his life on the streets. He was an angry man, lashing out physically and verbally at any nurse who dared to try to give him care. Moria was determined to meet his needs. She looked at him directly and said, "It's O.K. to be angry and afraid," and then she left. Minutes later when we returned to the room he was receptive to her offers of food and water. She had treated him with respect, acknowledged his feelings, and persisted with her belief that everyone deserves the best care possible.

To convey her view that every life has value Julie said, "All people with cancer are good people. We get to know what they are really like, we get to know their souls. They may have been shits before in their life, but we see inside and past all of that."

The record of a field observation reads,

> These nurses see past the cachexia, frail, broken, cancer ravished bodies to see the person inside. Today the nurse I was observing said, "She must have been such a beautiful woman, just look at her complexion and her hair." While all I could see was a disfigured shell, she was seeing the beautiful woman living inside her patient.

For the exceptional nurses, human beings are considered to be individuals having unique needs and perspectives. These needs not only vary from person to person, but also change as the disease progresses. During an interview

Julie stated,

> Our patients have many needs, they are different for everybody and we try to find out what they are. I ask my patients, "What is it that I can do for you?" or "If I could do one thing for you right now what would it be?" Sometimes I have to ask ten times before I get a response. But this way I find out exactly what their greatest needs are.

The same nurse went on to tell me this story.

> There was this one patient, when I asked her what I could do for her she said she was tired of wearing nightgowns, she wanted slacks. It was impossible to buy pants for her because she had this huge abdominal tumor and nothing would fit. She had nightgowns that she probably paid two hundred dollars for but she wanted pants. I ran home after work, got a piece of cheap material and sewed slacks that would fit by leaving the side seams open. I made them to suit her.
>
> Well, after I gave them to her the next day I had the sense that I had given her a million dollars. When I gave them to her, her husband was there and he just sat down and had a good cry. The family offered me all kinds of gifts because they were trying to say thank-you for this cruddy pair of pants. Actually, it wasn't the slacks, it was what it represented, that she was valued. It makes me feel so good to meet their needs. I just ride on clouds when that happens.

Patients with cancer often have different needs from those of well individuals. This point was made by Marie who said,

> All people have needs, but we really have to be sensitive to our patients because sometimes their needs aren't what you'd expect. Often, especially if they are dying, their physical needs like the need for food and water go way down, but I think their emotional and comfort needs like for giving and receiving love and for freedom from pain become most important.

Maureen commented, "Every patient is my favorite. I care about them all." Like many other nurse theorists these nurses believe that caring is the human mode of being. Roach's (1992) statement "I care, not because I am a nurse, but because I am a human being" summarizes her view of the nature of human beings. The nurses studied echoed this conviction.

The unusually competent nurses see people as being multidimensional, composed of physical, social, emotional, and spiritual aspects. The goal of integrated bio-psycho-social-spiritual wholeness and "health" of all components is their objective.

In their respect for life, their respect for individual differences, their belief that people generally care, and their feeling that people are multidimensional, the exceptional nurses views of human beings are consistent with the nurse theorists. However, the stories and comments they provided bring a human face to these values and beliefs.

The Theorists' Views on the Nurse-Patient Relationship

The nursing discipline exists because there are patients that require nursing services. In the nurse's work-life, the nurse-patient relationship is the primary inter-personal association. Though the nurse-patient relationship holds a central place in nursing practice, it receives little direct attention in the writings of the nurse theorists reviewed. Watson (1985) is the only selected nurse theorist who addresses the nature of the nurse-patient relationship specifically.

For Watson (1985), nurse and patient are co-participants. She has high regard for autonomy and freedom of choice on the part of both parties. In Watson's (1989) opinion, it is the nurse's responsibility to provide the patients with information and alternatives, facilitating their participation in decisions involving them.

Watson states that the nurse-patient interactions depend on establishing a helping-trusting relationship. This relationship becomes a mode of communication which establishes rapport and caring. Watson's (1989) characteristics of a helping-trusting relationship are congruence (genuine interactions), empathy (tuning into the feelings of clients), and warmth (positive acceptance of another often expressed by language, touch, tone of voice).

In Watson's view the one who is cared for can be the one who cares. This "nourishes the humanness of the care provider.... In such connectedness they are both capable of transcending self, time, and space" (Watson, 1989, p. 132). Neither the care-giver nor receiver stands above the other, the human centers of both people are involved. Watson calls this "human-to-human connectedness" and refers to it as "transpersonal caring." It begins when the care provider enters the life space of another and is able to detect the other's condition and needs (Watson, 1989, p. 131).

The Exceptional Nurses' Views on the Nurse-Patient Relationship

Like Watson (1989), these nurses believe that the nurse may sometimes be the recipient of care for the benefit of both the patient and the nurse. One nurse, Jane, told me this story.

> I walked by a patient room and I saw a nurse sitting on the bed. I took a second look because the patient had her arm around the nurse comforting her. At the time I thought it was a little unusual, maybe even inappropriate, then I realized that as nurses we have to be as human as possible. That might mean giving the patients the chance to be fully human too by allowing them the opportunity to give. When they are always on the receiving end, the nurse actually cares for them by letting them care sometimes too.

Due to the chronicity of cancer the nurse and patient often enter long-term relationships with one another, lasting a period of months or even years. This interconnectedness was demonstrated in Mindy's words. "We really get to know each other. We laugh together, and cry together. We need each other to hug, to help, to teach, to share, to love. We are in this together."

The nurses see their part in the nurse-patient relationship as that of facilitator. Patients and family members retain control of the decisions that affect them. Jane summed it up like this, "Patient and family wishes are paramount. They are the directors of care." Consistent with Jane's perspective, Maureen described her role this way, "My role is to help patients and family members make decisions by giving them options. My purpose is to give them options and to lead them to a good choice."

To summarize, the exceptionally competent nurses suggested that the nurse-patient relationship, which is often long-term in nature, may be mutually beneficial.

That is, at times the patient may nurture the nurse as the nurse provides nursing service to the patient. This follows from their belief that most people, including patients and nurses, generally are concerned about the welfare of others. A primary pillar upon which the nurse-patient relationship is built is the belief that the patients are directors of decision-making regarding their care.

The Theorists Views' on Nursing

As anticipated, all of the nurse theorists reviewed made statements in their philosophies about the nature of nursing. Although they agreed that nursing is essentially a goal-oriented inter-human process, they each provided their own beliefs regarding the fundamental goals of nursing.

An early theorist, Peplau (1952) describes nursing as a healing art, assisting individuals who are sick and in need of health care. Like more recent theorists, she depicts nursing as an inter-personal process because it involves interaction between two or more individuals with a common goal. For Peplau (1952) these goals are mutually agreeable and nursing interventions are directed at achieving them.

Peplau (1952) was one of the first theorists to recognize nursing as a "maturing force and an educative instrument." In her estimation, both the nurse and patient learn and grow as a result of their interaction. As they work together, they both evolve in the process. She maintains that mutual respect is a necessary pre-condition for this to occur.

In the view of Benner and Wrubel (1989), nursing is, in part, looking for the meaning of the illness. They suggest that understanding what the illness means for the person, and for that person's life, is a form of healing. Such understanding, Benner and Wrubel (1989) claim, can overcome the sense of alienation, loss of self-understanding, and loss of social integration that accompanies illness (p. 9).

Benner and Wrubel (1989) are known for their research that suggests that nurses move through stages of increasing competency during their careers. They state that at any point a given nurse will be somewhere on the novice-to-expert continuum. According to Benner and Wrubel (1989), as a nurse moves through this continuum there is transition from reliance on abstract principles to the use of experience as a guide for behavior. The nurse also begins to see a situation as a complete whole in which only certain aspects are relevant. Finally, while the novice nurse is a detached observer in patient care situations, the expert nurse, according to Benner and Wrubel, is an involved performer.

Nursing expertise in their view is gained through "experience" which they define as "more than the mere passage of time...rather as the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory" (Benner and Wrubel, 1989, p. 36).

Parse (1987) also emphasizes the inter-personal nature of nursing, but her descriptions of these relationships make a unique contribution. She defines nursing practice as "a subject-to-subject interrelationship, a loving, true presence with the other to promote health and quality of life.... Nursing means being with rather than doing for" (p. 69).

She sees the role of the nurse as that of guide. The nurse is not to decide for the patient, but to facilitate decision-making. She believes nursing practice should be "innovative and creative, unencumbered by prescriptive rules" (p. 69).

In Parse's (1987) view nursing practice is three dimensional. First, the goal of nursing is illuminating meaning, the nurse guides the patient to understand the meaning of the situation. Second, nursing practice is "synchronizing rhythms which happens in the process of dwelling with the flow of the inner human cadence" (p. 69). Rather than calming or trying to balance these rhythms the nurse goes with the rhythms set by the individual or family. "The nurse leads them, through discussion, to recognize the harmony that exists within the family's own lived context" (p. 69). Third, nursing is "mobilizing transcendence." This, according to Parse (1987) happens when the nurses guide their patients in setting goals or, as she states, in "dreaming possibilities" (p. 69).

For Parse (1987) quality of life is an important consideration for nurses, a principle that guides their actions. This view is shared by another team of nurse theorists, Paterson and Zderad (1976) who outline a humanistic nursing practice theory based on their belief that nursing is an existential experience. For them, nursing is a lived dialogue that involves coming together of nurse and person to be nursed. Nursing is a special kind of meeting of people, a unique lived dialogue.

For Paterson and Zderad (1976) the essential characteristic of nursing is nurturance. Quality of life is the principle guiding nursing action. They define nursing as "a nurturing response of one person to another in a time of need that aims toward the development of well-being and more-being (human potential)."

While humans need nursing, Paterson and Zderad (1976) contend that nurses need to nurse. This nurse-patient exchange results in a real "sharing" and "relating." These theorists suggest that to be effective the nurse needs to be committed to being with the patient and to be open, receptive, ready, and available to this other person in a reciprocal manner.

Like Benner and Wrubel (1989) and Paterson and Zderad (1976), Watson (1985) also talks about the nurse's role in helping the patients gain harmony with themselves. This self knowledge helps patients discover meaning in their illnesses.

As illustrated by the following quotation, Watson's (1985) claim is that care is the essence of nursing.

> Nursing care can be and is physical, procedural, objective, and factual, but at the highest level of nursing, the nurse's human care response, the human care transactions, and nurse's presence in the relationship, transcends the physical and material world,...and makes contact with the person's emotional and subjective world as the route to the inner self and the higher sense of self. (p. 50)

In the actual caring occasion "two persons come together with their unique life histories and phenomenal fields in a human care transaction" (Watson, 1985, p. 58). The phenomenal field is the subjective reality or individual frame of reference of the person. At these times, each participant is touched by the human center of the other.

Watson (1985) believes the nurse matures to have a value system which promotes faith and hope, and emphasizes the spiritual. If medicine has no cure for a person, the nurse can continue to use faith and hope to provide a sense of well-being through those beliefs meaningful to the individual.

Roach (1992) is a more recent nurse theorist who, like many of the other theorists discussed, emphasizes caring in her discussion of nursing. She defines nursing as the "professionalization of the human capacity to care" (p. 41). In her opinion caring is not unique to nursing in that it distinguishes nursing from other professions or avocations; rather, caring is unique in nursing (p. 41).

For Roach, caring is a universal concept that subsumes all others. She believes that nursing does not differ from other helping professions in that nurses care, but it differs in the manner in which they care. Nurses care within specific roles, using a distinct body of knowledge and skill.

Consistent with her views on the nature of health and the nature of human beings, Leininger (1985b) continues to emphasize culture in her discussion of the nature of nursing. She focuses on a particular area of knowledge as being important to the nurse, that is the culture of the client. Leininger (1985b) stresses the importance of understanding the similarities and differences of people across cultures. Care and caring are dominant and central domains of nursing for Leininger.

In summary, most of the theories reviewed described nursing as a goal-oriented, deliberate, inter-personal process. The nature of the fundamental goal differed between theorists. Those writing from a phenomenological paradigm - Benner and Wrubel, Parse, Watson, and Paterson and Zderad - suggest that a search for the meaning of the illness is a primary consideration. For two of these theories, one authored by Parse and the other by Paterson and Zderad, quality of life is a central concern, the principle that guides nursing decisions. Other theorists indicate that nursing is primarily a "healing art" (Peplau), or "caring" (Roach, Leininger, and Watson).

Peplau (1952) was an early theorist who emphasized the educative and growth potential in being a nurse. Watson echoes this belief with her suggestion that human-to-human connectedness results in a two-way exchange where both the nurse's and patient's needs are met. Paterson and Zderad (1976) describe nursing as an "existential experience" which could also result in personal development for the nurse.

Although the notion of caring is more central to some theories than to others, it is included in some way in all of them. Some theorists such as Watson, Roach, and Leininger described it as the "essence of nursing." Others incorporate it into their philosophy in a less central place; however all the theorists either explicitly or indirectly describe nursing as caring about others and either meeting their needs for them or helping them to satisfy their own needs.

The Exceptional Nurses' Views on Nursing

Like the nurse theorists reviewed, the exceptional nurses define nursing in part as an intentional, goal-directed, and accomplishment-oriented process. For them though, nursing centers around the nurse-patient relationship and they therefore cannot speak of nursing apart from the recipients of nursing services. Jane said, "The patients are the only reason we are here. Giving direct patient care, actually laying your hands on real people, that's nursing. To be a good nurse you have to get really close to your patients, share part of yourself."

In a conversation Mindy shared this story with me. It describes her definition of nursing within the context of the nurse-patient relationship.

> I was taught in nursing school not to get too involved with my patients, to keep a "professional distance." I think this is a barrier to being a really good nurse. I have to get involved with my patients in order to assess their needs and plan and deliver their care. We are expected to do intimate and personal things to our patients and discuss intimate and personal issues with them. You just can't do that and keep your distance too. All good relationships have an element of sharing in them and the nurse-patient relationship has to as well if it is to be successful, if nursing is to occur.

The contribution that the nurse brings to the health care team in terms of knowledge of the physical, emotional, and spiritual needs of the patient is stressed by the nurses. Two nurses interviewed express it this way.

> Nurses are the key people for the patients to communicate their needs to because we are available all day and all night to the patients and their families.

> We see the patients at their best and at their worst. Nurses really get to know their patients, especially during the night shift. The darkness seems to bring out their greatest fears and sometimes when they can't sleep they are ready to talk about how they really feel and what they really think.

For these nurses, it is an important nursing role to communicate the patient's fears, needs, and choices to other members of the care team. In part, the exceptional nurses suggest nursing is coordinating the communication of patient needs to the appropriate multi-disciplinary team members.

To the nurses studied, nursing is more than the problem-solving nursing process of assessment, diagnosis, planning, implementation, and evaluation. Their approach to patient care is not as linear as the problem-centered textbook process suggests. When I asked them about their "nursing process" the reactions varied, as follows:

> You know the more I nurse, the more complex I see it is. I used to think following the nursing process would make sure I gave good care, but as I get better at what I do I realize that it really doesn't work for me anymore. I don't follow any steps, I just sort of do it all at once.
>
> Many times when I go into a patient's room I don't have a plan in mind, I just make it up as I go along. By looking at the patients and talking to them, I just instinctively know what they need and I do it.
>
> This is my process. I assess, really look and find out what is going on. My assessment is ongoing, almost habitual. I can't say I really have a plan, but if I do, it is ever-changing. My care is provided with the patients, not to them, and I evaluate constantly.
>
> For many of my patients, especially the dying ones, I don't really do anything for them, no fancy nursing interventions anyway. I'm just there.

All the nurses studied referred to the feelings they have about their profession. The following are five of the nurses' expressions of their satisfaction with their career choice. Common themes running through these comments are the opportunities for human interaction and the chance to make a difference that nursing offers.

> I think of few careers where you can interact with people so closely and feel so helpful to someone. You feel like you really make a difference. It is important to me that what I do is worthwhile.
>
> Nursing invites you into places you would never go, across the barriers to people, holding their hands and being close. A lot of patients have made a difference in my life and they will never know it. Not all jobs

> give this amount of personal reward.
>
> It is wonderful to make a difference to peoples' lives. I think we all wrote in our essays for entrance to nursing school, "I want to help people." Well, here I get a chance to really do that.
>
> I'm really fortunate [to be a nurse]. I love this!
>
> I have never had a choice not to work, but I do have choices in what kind of work I do. I could be washing windows; I could be sweeping sidewalks; I could be doing dishes, which I hate. I have to work so I might as well be doing something I enjoy doing. I like people so I chose nursing. When I was a kid I used to clean barns and clean granaries and I vowed I would never do that. I chose nursing and I love it.... Every time you turn around someone is saying thank-you.

To the participant nurses, nursing is seen as rewarding, a great opportunity to learn skills and develop as a person. The nurses talked about nursing care being complex and demanding, yet they saw it in a positive light focusing on the opportunity for personal development. Jane commented,

> When you first start nursing, after about six months when you have some confidence, you think, "Boy I'm doing a great job!" Then you realize as the years go on that everyday you are still learning. Look at me, ten years and I still learn something each day. I'm glad because it helps me give better care and be more creative.

Marie said,

> Nursing results in mutual growth for the patient and the nurse. I don't believe nurses who let themselves get involved in these satisfying nurse-patient relationships ever burnout. I get back as much, maybe even more, than I give.

For these nurses the patients always come first. The patients are consulted about their care decisions. Quality of life, as the patient defines quality, is of primary concern. Maureen remarked that for her, "Nursing is making yourself aware of the patient's perspective and helping them, guiding them to make their own choices, choices that are best for them." Lana simply said, "Quality of life is the whole goal when a cure isn't going to be there."

As the following quotations attest, the theme of caring was laced throughout the exceptional nurses' comments and stories about the nature of nursing. These are just a few of the comments that communicate the central place of this concept in their philosophies of nursing. "Nursing is caring." "I really care about my patients. I want the best for them." "I am here because I care."

One of my early field notes reads,

> This lady cares. How do I know? She says she does but that's not the only way. She wants the best possible quality of life for the patients. Their best interests are central to all of her actions and decisions. Today one of her patients was not responding to her. He just wanted to give up on life. It would have been easiest for her to give up on him, but she said, "We have to find a way to get through to him," and she kept trying until she succeeded.

To summarize, through their actions and words it is apparent that the exceptionally competent nurses view nursing as important, complex work; work they feel privileged to participate in. Oncology nursing is seen as an opportunity for continued professional development, a value they all hold. They fulfill their responsibilities keeping in mind that the patient's quality of life is a primary consideration. In keeping with the views of Roach, Watson, and Leininger, these nurses believe that nursing cannot be separated from caring.

The Exceptional Nurses' Views on the Nursing Milieu

The nursing milieu, or environment, is not a central concept in most of the theories reviewed. However, Watson (1985) contends that the environment is important in promotion and restoration of health and in the prevention of illness. She emphasizes that consideration should be given to the "mental, physical, socio-cultural, and spiritual environment" and nurses should work towards providing environments that are supportive, protective, and corrective.

Agreeing with Watson's statement, the exceptionally competent nurses acknowledge that as a patient is multi-faceted, so is that patient's environment. Nurses, in their opinion, need to consider all aspects of the milieu. They focused on the benefits derived by the patient when the depersonalizing hospital environment is personalized.

There were comments from the nurses interviewed about the various patient environments. The physical environment was primary, but they also spoke of the importance of the social environment (the inclusion of family and friends), and the emotional environment (the feel of the place). In the nursing unit I studied they deliberately tried to create a "home-like" environment that was physically, socially, and emotionally beneficial to them as well as to the patients. Peter emphasizes this in the following comment:

> We want patients to feel at home so we invite them to

> make their rooms their own. We suggest they bring in personal articles such as pictures, plants, comforters, and ornaments. Family members and friends are encouraged to visit anytime and we make sure all special occasions, like birthdays, are acknowledged.

Julie further supports this saying,

> Here we do little things like calligraphy name cards for the patient's doors, using real china cups for tea, and lace table clothes for parties, little things that make a big difference.

Although it is important, more than a change of furnishings and the addition of decorations are needed to create a home-like environment and these nurses sensed that. At coffee break Jane said,

> We have to make it look like they are at home, or at least like they are in familiar surroundings, but we also have to make them feel (as much as we can) that they are at home. A lot of this comes by encouraging them to wear their own clothes, make choices, and control their own routines.

Bottorff (1991a) makes a similar observation. She writes, "Health care environments can become a home away from home not just by changing the decor but, more importantly, by allowing the patient to be at the center, the center of each day" (p. 249). Bottorff (1991a) suggests that helping the patient feel at home provides a measure of comfort.

Some nurses talked about the energy in the environment commenting that human encounters involve exchange of this energy. As illustrated by the following comment, the strength of this force in patient-nurse relationships and in the larger environment was considered a factor in creating a positive psychological milieu. Julie comments,

> We try hard to create a positive energy here. When people find out they are going to a cancer ward they envision darkness and grief, all that negative stuff. They are surprised when they come here and see what a cheerful, bright, and happy place it is. But we work to make it this way.

In further analysis of the nursing milieu, it is evident from my field notes that the environment in which the nurses work can be separated into public and private spaces. Goffman (1959) labels these as "front-stage" and "back-stage" areas. Although the nurses did not introduce these divisions directly, a brief discussion of these spaces may be useful.

The front-stages spaces are those in which the nurses and patients come into contact. For example, the patient rooms or the nursing station areas. The back-stage areas are those in which the nurses are separate from members of the pubic. While in the medication or conference rooms for example, the patients and family members could not see or hear the nurses. One field note discusses the back-stage behaviors of the nurses.

> After reading Goffman's work The Presentation of Self in Everyday Life (1959), I expected to find the nurses engaging in very different behaviors "back-stage." However, among the nurses I am observing there seems to be consistency between their front and back-stage demeanor. While I anticipated that the nurses might seek privacy in back-stage spaces in order to express their emotions, I am observing that they generally share their grief, anger, frustration, and joy front-stage with their patients. There is a genuineness and openness about them. These nurses don't seem to need to put on their performance faces before they emerge from the back-stage areas because they are the same people no matter where they are.
>
> The nurses seem to be taking off their masks rather than putting them on. Perhaps this encourages others to do

> the same. As the nurses reveal themselves to others, they also reveal themselves to themselves. Authenticity leads to self-awareness and self-awareness to authenticity. To be yourself you must first know yourself.
>
> One exception to this observation is the use of black humor. The nurses do engage in some joking of the gallows type with their colleagues when they are back-stage. However, I have also observed them sharing black humor front-stage with their patients.
>
> Initially I thought that it might be they were still performing for me as they went into back-stage areas. However, over the length of the study I continued to observe the remarkable consistency in their approaches.

Consistent with my observations regarding the unchanging front and back-stage behaviors of the study nurses, the values of honesty and genuineness were articulated by several of the nurses interviewed. Julie emphatically stated, "It's just basic respect not to lie; its part of my philosophy. I want to be treated that way myself, I don't want to be lied to because if you lie to me, I don't know where I'm at." Maureen said, "I give information to patients and family members. I am always honest. It helps them come to an acceptance of what is happening." By living the values of honesty and genuineness the nurses positively affected the environment created.

To summarize, the exceptional nurse's views of the nursing milieu, they acknowledge that as a patient is multi-dimensional, so is the patient's environment. Nurses, they believe, need to consider all aspects of the milieu. They focus on the multiple patient benefits derived when the hospital environment is individualized.

The energy flow in the environment, and between people, is something these nurses were conscious of. Spending their energy to maintain a positive atmosphere is seen as necessary.

Contrary to what is described in the literature, the exceptionally competent nurses generally did not present different facades in back-stage and front-stage areas. Rather, they were most comfortable being genuine in both environments. In their actions, as well as their words, these nurses expressed a determination that honesty and genuineness are important values influencing their practice.

The Exceptional Nurses' Views on Self

While in many of the theories reviewed the nature of self was explored indirectly, the exceptional nurses were specific in their views about the nature of self and the importance of self-awareness. From among the selected nurse theorists, Watson (1989) and Paterson and Zderad (1976) did stress the importance of self-awareness for nurses. Watson said, "Each nurse must turn inward to face his or her own existential questions before being able to assist others to cope with the human predicament" (p. 58).

Watson (1989) suggests a nurse needs to feel an emotion as it is experienced. In her judgment, it is through development of one's feelings that one can genuinely and sensitively interact with others. When this happens, the nurse becomes more authentic which is for Watson, part of self-growth.

As Watson, Paterson, and Zderad would anticipate, the exceptionally competent nurses had developed views about the nature of self. They talked about the importance of being self-aware at several levels including awareness of their physical self, emotional self, and spiritual self. This awareness, the nurses believe, comes through a combination of experience and introspection. In Jane's determination,

> You learn by being honest with yourself and trying to learn what kind of nurse you really want to be. You learn from your patients, from your mistakes, from thinking about what you did and why it worked or it didn't work. You have to keep thinking, how can I improve?

The physical self. The physical self includes knowing one's body and ensuring physical needs for sleep, exercise, and nutrition are met. In talking about striving for "total wellness" Julie said,

> I take care of myself.... If you are frustrated trying to meet your own needs how the wonder are you going to meet someone else's needs. If you haven't decided what is important for yourself and what isn't important how are you going to take these fragile family situations and give them any direction or help?

She went on to describe the part her uniform and her physical appearance play in her success as a nurse.

> You don't have to wear a label that says you are a nurse when you wear a uniform. I stretch the limit of the uniform.... I have always been a provocative dresser. I do it as a statement of individuality, because I like to be identified. If you care enough about yourself to dress well and appropriately then the patients will feel cared about too. If you go looking like a slob how can they possibly have confidence in you? If you can't care enough to put your best foot forward then how can

> you care about your patients? If you can't have your sweater matching your uniform, then you don't care very much...and the more you care about yourself, then the more you are available to care about others.

The spiritual self. Most of the nurses provided insights into their beliefs about the spiritual self. In several cases, this sense of self developed as they cared for dying patients, or faced questions about the existence of a greater power, life, and death. Some talked about their belief in God, a higher power, or angels, and the power of praying for and with their patients. The following story illustrates this well.

> The process of dying can take a long, long time. Mr. Paul had been in the last stages for about two weeks. He was a very religious and devout family man. We had shared many memories together, many discussions in the previous months of his illness. I was there when he was initially diagnosed and had come to know his children quite well. His family had been keeping vigil day and night at his bedside. They had been reading to him, praying his very favorite prayers, and leaving him distance as well. He was very at peace with his dying. But, why, why was this taking so long?
>
> It was Tuesday morning. I was not his nurse that day. His nurse met me in the hallway. She felt that soon he would die. His apnea spells were far too long, his extremities cold and mottled. I whisked through the hallway and caught sight of his wife and two daughters. I clutched one hand and one shoulder and whispered, "It's time." I'm not sure if they knew at that time what I was suggesting. I walked them into the room as quickly as possible. I placed one of his hands in his wife's, and the other hand in his daughter's. I nodded and simply stated, "He's going home."
>
> Tears flowed as they said good-bye. I cried too. No matter how prepared you are for death the final moments are always hard. I felt very privileged to be present during this time as many of his family were not there yet. His other children had all been called by this time, and they were on their way.
>
> In a short while all of his children and their respective families arrived and we ushered them into the

> room. They formed a circle around him, joined hands, and extended their hands to me, inviting me into their family. Together they recited an "Our Father" and prayed for his safe journey.
>
> I can't tell you how very special I felt to be a part of that intimate circle. It was a gift that would give me a great deal of strength in the deaths I would stand by in the days to come.

Reflecting on this story in conversation Marie, the nurse who wrote it, said,

> I often pray for my patients now. When they are dying I pray for them out loud, at that moment. It is my way of assuring their safe passage. I truly believe it and I know if they are aware they would understand. Really, it's for me as well as for the patients.

Another story speaks about the power of prayer in her practice.

> She was exactly my age. But that's where our similarities ended. She arrived back early from a Sunday pass and we were overlooking the city from the window of her hospital room. It was a hot summer afternoon. She was worried about her only family member, her ten year old son. He was so precious and I had come to care for him deeply. I recall he was wise far, far beyond his years and had taken over as care-giver for his Mom.
>
> His Mom had advanced breast cancer which was extremely rare for someone her age. She had suffered greatly all her youth in a war-torn country. Recently, she had escaped to Canada and here had suffered an abusive marriage. This all preceded her fatal diagnosis. She was very much alone. As I learned more and more about her, I was chilled by her history.
>
> As we talked that day, tears streamed from her eyes. She turned to me and asked, "Why Marie? Why do these things happen? Does no one care about us?"
>
> We were watching people outside enjoying the summer day. I immediately felt trapped inside as she did. Nothing I had been taught made sense right now. I could not answer her. Tears clouded my eyes as my gaze met hers, all I could say was, "I don't know why. I wish I could tell you."
>
> I thought what a feeble, feeble answer. I paused for a

> long time sitting with her. Then I opened up and told her that I was a Christian and that the only thing I knew to offer her were my prayers. I exposed myself to a patient like I had never done before. She thanked me and then said, "I am a Buddhist, can I pray for you too?" I said I would be grateful to receive her prayers.
>
> Perhaps there is something more we had in common. We both had a good Sunday evening.

Marie added a post-script during a follow-up conversation. She said, "I was just totally blown away that someone could have such a devastating life. I didn't know how to answer her, so all I could do was pray for her."

Julie told me how she uses angels in her practice. She said,

> People really respond well to talking about angels.... No matter what their faith most people have some belief in an after life. The angel represents for them whatever they want it to represent. For some people it's a safe way to talk about death without using the words. I have been here three years and I have received ten packages in the mail with angels in them.... I don't always know where they came from, but something has connected.

Jane in particular talked about becoming comfortable with sharing her spiritual self with her patients. She made the following remarks:

> Spiritualness is part of my practice, but it is a very personal part. Sharing your faith is not seen as a professional thing to do, and in nursing we are taught to be professional so I am hesitant to talk about it and admit to you that it is a part of my care. To me it can be the true essence of everything, of life, of death. I do share my own beliefs if they are asking and they are feeling lost. I feel comfortable because I have my own beliefs together. People ask a lot of questions about the end, where they are going...especially if they haven't finished their business yet. But you do have to be careful. Sometimes I just pray to myself.

The emotional self. The nurses described what I have labelled emotional self-awareness. They talked about being "open to feeling the emotion of the moment, and being willing to share those feelings appropriately with others." During their careers they had come to know themselves and to be sensitive to their emotions. Lana commented, "I always believed that if I couldn't recognize an emotion in myself like anger or sadness, how would I know it when I saw it in a patient?" Maureen concluded, "You have to know where you are at. If you don't know where you are coming from how can you be available to help others?"

Developing self-awareness. There was recognition that developing all types of self-awareness is a process that includes recognition of one's limitations and strengths. Peter described part of his self-discovery,

> I have come to know my own strengths and limitations and I work from there. Some nurses are good with details, but that's not me. I go very slowly when I give out medications. After making a med. error I realized that I'm not perfect and I need to take my time with that task.

Initially, it was surprising, maybe even disappointing, to me that these exceptionally competent nurses were not perfect. As I watched and listened I realized that this ability to admit imperfection and to identify ways of overcoming or compensating for these identified areas of weakness was possibly a component of their success and evidence of a level of maturity.

Most of the nurses talked about being interdependent, a part of a team. This seemed to be one of their major means of compensating for their own limitations, identifying and using the strengths of their colleagues. Jane said,

> At first I was totally dependent on my colleagues to survive a day of work here. I was constantly needing help from others. Then I went through a time where I was extremely independent. I tried to do it all alone, I thought if I asked anyone for help I had failed. Now, I don't worry if I don't know how to run a machine or the answer to a question, I just ask someone who does know and I'm really comfortable with that. But I make a point of sharing the things I do know too.

These nurses appear to share the belief that they continue to grow from their experiences and they talk about being continually refined. The idea of developing a maturity as a result of their patient encounters was common. Peter noted, "I know I've become a better nurse because of working here."

In summary, the importance of self-awareness, including awareness of the physical, spiritual, and emotional self was identified and illustrated by the exceptionally competent nurses. This consciousness developed over time through experience and introspection. The development of self-awareness is viewed as a process. Identification of one's limitations and strengths were part of this self-discovery. A common sentiment is reflected in Jane's words. She said, "Working here I have learned so much about cancer, but even more important I have learned so much about myself. This no one can ever take away from me."

The Exceptional Nurses' Views on Life and Death

The oncology nurses studied shared their beliefs about life and death. Although these concepts are not addressed specifically in the selected nursing theories discussed in this chapter, I think they are important parts of a fully described nursing philosophy. The concepts of life and death are discussed in several other bodies of literature and statements drawn from these sources are incorporated into this discussion.

Perhaps because of the nature of their work, the oncology nurses participating in this study had developed their views of the topics of life and death. They talked and wrote about how they came to their own acceptance of death as a part of life. Samarel (1991) said, "If a nurse has learned to accept death and more importantly, has learned to accept that some individuals may accept death while others may fear it, she is better prepared to accompany her dying patients on their journey toward death" (p.72).

There was acknowledgement from the exceptional nurses that coming to an acceptance of death was very difficult to do. Maureen said, "For all of us, at any time in our lives, dealing with death is one of the most difficult experiences we will ever face."

In describing the process of learning about and accepting death the exceptional nurses shared these observations.

> We all had to start by being honest in dealing with our own feelings about death. It took me a long time to accept even after working here for more than a year, that young people, people my age, even babies die of cancer. Once we have worked through our feelings we are better able to be honest and comfortable with our dying patients.
>
> It is important to come to terms with grief and the multiple losses you encounter working with cancer patients. But it is hard to do without being here because in society in general people don't talk about having cancer, or about dying.
>
> We live in a world where being busy is important, we like to do things. We can "do lunch" but we can't "do death."
>
> Of course we think more about death than most people do. We face its reality everyday. I have come to believe, although it has taken a long time, in a spirit or soul that lives on beyond the physical shell that is left behind when someone dies.
>
> You have to start by understanding yourself and your own feelings about death and about dying people.

These nurses acknowledge that birth and death are something we all share. This thought is communicated in Lana's words. "When you see a person die, laying there in the bed not breathing, getting cold, you can't help thinking; my God, I'm going to die too. Funny but it's a startling revelation at first."

As Paterson and Zderad (1976) said, "We need to become aware of the reality of death to experience the significance of living" (p. 280). The nurses interviewed talked about how life had become more precious since confronting death frequently as an oncology nurse. Here are some examples of their comments:

> Now I consider life precious, something to be valued moment by moment. Facing death and your own

> mortality makes you more aware of the pleasures of life.
>
> Sometimes I just think, anyone of these patients would gladly give anything and everything they have to be as well as me for even five minutes.
>
> You come to realize that life is so fragile, so temporary.
>
> Working here makes you more comfortable dealing with crises in your own personal life. In the light of what you see your own problems don't seem so great. I have come to value my health. Without it we don't have much.
>
> Working here is what tells me I am doing the right things with my life.
>
> If I come to work with a headache, or I'm angry at my husband as soon as I see my first patient it is gone. I think what right do I have to complain. My life is great. I'm alive. I'm healthy. You just find yourself appreciating everything more after working here. You don't take anything for granted.
>
> Death makes life beautiful. If there was no death, if we were not conscious of it, each moment along the way wouldn't be as beautiful. Knowing death helps you live each day as if it were your last, but also as though you have an eternity before you.

The nurses participating emphasized the importance of death as a rite of passage, a significant life event. A nurse, Moria, told me, "Life and death are such a part of everything." Another nurse, Julie, said,

> Death is important, an occasion of life, the final event, I believe that it should be celebrated with family and friends. However, each person has the right to prepare for and face death in their own way, the nurse is present to help them do that. Just as no two people live the same life, no two people die the same kind of death. Nurses need to reach beyond their own feelings about death and give the patients the support they need.

The nurses were determined that life continue even for the dying. Mindy described her goal of "keeping the living, living until they die." The nurses accomplish this, in part, by helping their patients continue to enjoy their favorite hobbies and interests, their families and friends, and by assisting them to set realistic goals.

Death was not seen as a failure to these nurses. Helping a patient to a pain free, peaceful death was considered the leading goal for patients who were terminally ill. Peter, who had been with several people as they died said,

> Death is not a negative thing. It is like we are on one floor of a building now and when we die we get on an elevator and go to another floor. If I can help my patients do that with dignity and without pain then I have succeeded.

They talked about death being difficult when the patient is ready to die, but death takes a long time to come. Julie observed, "Waiting to die can be boring." Marie told me a story about one of her patients who had a long wait.

> One thing that he shared with me was that he was really ready to die. It was a long process for him. He wanted to die on St. Patrick's day, but the day came and went and he was still alive. I went into his room that night and I just said, "I'm so sorry. Today was the day and you were so prepared." It was like he had been anticipating going somewhere and he was really disappointed.

In recalling the death of one of her patients Jane said, "It was a beautiful death. It wasn't happy of course, but it was encouraging." O'Banion and O'Connell (1970) conclude, "Talk of life and death, that's the only real subject there is. Everything else is bits and pieces of it, of life and death I mean" (p. 172).

In summary, death was unfamiliar to most of the participants before they became oncology nurses. Their acceptance of death as a part of life, a time to be celebrated, seemed to come about as a result of their nursing experiences combined with personal introspection. Helping a patient to a peaceful death was viewed by them a legitimate nursing goal. For these nurses, facing death appeared to place their own lives in perspective.

CHAPTER SUMMARY

In addition to having a unique perspective on the nature of health, human-beings, nursing, nurse-patient relationships, and the nursing milieu, the exceptionally competent nurses expressed well articulated beliefs regarding the nature of self, and life and death. The underlying values of honesty and genuineness, combined with a desire from ongoing personal and professional development were demonstrated in the words and actions of the nurses studied.

This striking similarity in their beliefs and values was revealed during the study, however the reasons for this shared perspective were not pursued. Regardless, this finding does raise interesting possibilities for future investigations.

The Nature of Health

In short, the nurse theorists reviewed generally agree that health is more than absence of disease and that complete health involves the integrated functioning of mind and body.

The exceptionally competent nurses suggest that health is achieved when patients are assisted to function at their full physical, emotional, and spiritual capacities. Patients can be healthy even when disease is present in their bodies, in fact, for some disease can lead to health.

The Nature of Human Beings

The exceptionally competent nurses and the nurse theorists reviewed share a reverence for life and value each individual. People are believed to be multidimensional and capable of making choices and of caring for others.

The Nurse-Patient Relationship

Watson (1989) is the nurse theorist that makes the most specific comments regarding the nurse-patient relationship. She suggests that nurses and patients are co-participants. That the one who is cared for can also be the one who cares. She labels this "transpersonal caring."

The exceptionally competent nurses also believe that the nurse-patient relationship may be mutually beneficial. They expect that all people are generally concerned about the welfare of others and that it is important for the well-being of both patients and nurses to have to opportunity to care.

The Nature of Nursing

The nurse theorists agree that nursing is a goal-oriented, deliberate, and inter-personal process. Among the theorists the fundamental goal of nursing differs from helping the patient find meaning in the illness, to helping the patient attain the highest quality of life, to nurturing and caring.

Peplau (1952) emphasizes the educative and growth potential of nursing and Watson (1985) writes extensively about the human-to-human connectedness that results in a two-way exchange where both the patient's and the nurse's needs are met.

The exceptionally competent nurses view nursing as important and complex work. Generally, these nurses agreed that nursing can not be separated from caring and that it provides great opportunities for personal and professional growth.

The Nature of the Nursing Milieu

Both the nurse theorists and the nurses participating in the study indicate that the patient environment is multifaceted. The exceptional nurses strive to achieve a home-like milieu and emphasize the multiple benefits that result from this.

The Importance of Self-Awareness

The exceptionally competent nurses comment on the importance of self-awareness, specifically awareness of the physical, emotional, and spiritual self. In their opinion, this consciousness develops through a combination of experience and introspection.

Life and Death

By the nature of their work most of the nurses studied had faced death on many occasions. They display an acceptance of death as a part of life. They suggest that encountering death caused changes in how they approach life.

In summary, when comparing the expressed beliefs and values of the nurses studied to those of the nurse theorists reviewed, similarities in some aspects were noted. However, the exceptionally competent nurses go beyond what is reported in the literature to articulate a finer appreciation of the value of self-awareness, and a profound understanding of life and death. Their comments and stories bring a human face to their philosophies of nursing.

REFLECTIONS ON THE EXCEPTIONALLY COMPETENT NURSES' PHILOSOPHIES

The most consistent aspects of the philosophies of the exceptional nurses are a belief that life is precious; a respect for the dignity, worth, autonomy, and individuality of each human being; an awareness of the value of self-understanding; a commitment to helping each patient attain the highest quality of life possible, with quality being defined by the patient; an acceptance that death is a natural part of life; and a resolve to act according to their philosophies. By their words and actions it was revealed that the exceptionally competent nurses value honesty, genuineness, and ongoing personal and professional development.

The overarching finding from this chapter is that these nurses seem to have been, and continue to be, affected and transformed by their work. An elaboration of this finding is provided by the following poem:

NURSE TRANSFORMED

Shaped and molded daily by
a constant stream of challenges,
you continue to evolve.

Each time you confront death,
all life becomes more treasured.

Now,
you approach life with a sense of urgency,
eagerly soaking up all of the
pleasures and pains it offers.

You want to change the world,
to make a difference in the lives of
those who need you.

But all the while
you recognize that you too must be sustained
and you receive as openly as you give.

With gratitude
you accept and welcome these changes,
and anticipate your continued transformation.

Chapter 5

THE DIALOGUE OF SILENCE

CHAPTER INTRODUCTION

Silence: pure, precise, and in a sense, perfect. There is little written about it. Silence is seldom a direct focus of research because silence is difficult to observe, record, and write about.

This study was not designed to be a study of silence. Yet silence emerged repeatedly as an approach used by the exceptionally competent nurses. As I observed them with their patients and re-read the interview transcripts and the stories of their significant practice moments, it was clear that they often used silence during emotional or difficult patient interactions. Beyond these more extraordinary times, silence also played an important part in their everyday nurse-patient encounters.

Silent moments were a part of most nurse-patient exchanges. In few day-to-day human interactions is there constant, relentless verbalization. However, the silences that were part of these nurse-patient encounters were different from our average customary pauses. Most times these silences, or gaps in speech, were rich in non-verbal communication. Messages that were difficult or even impossible to speak, were sent from nurse to patient and from patient to nurse in silence. When everything that needed to be said had been said, when cultural or language barriers inhibited spoken communication, when the patient was confused, when the news was bad, when there were no "right" words, and when no words were necessary, silence was used.

There were many benefits or gifts that resulted from silence. Specifically, patients received the gift of the nurse's presence and the gift of being listened to with openness. Through providing these silent gifts, the nurses also received, making this silent dialogue beneficial to both the patient and the nurse.

From the data it was apparent that the silence came in varying forms. For example, non-verbal messages framed in silence, silent messages encoded in words, and silent messages encoded in actions are forms of silent interplay recorded and consequently reported in this chapter. The commonality of many of the silent moments was the two-way quality. Therefore, I have called this chapter the dialogue of silence.

In this chapter I combine some of the stories written by the nurses studied with field notes from my observations and excerpts from conversations I had with the study participants. These narratives illustrate the uses, gifts, and forms of silence as well as how the nurses came to learn to use silence in patient interactions.

To provide a hermeneutic analysis of some of these examples, a poem that I believe exposes the nucleus or heart of the narrative is presented. I consider poetry an appropriate medium of analysis because it is a bridge between non-verbal and verbal expression and it allows for communication in a succinct and creative way. Poems potentially expose the tacit, that which is difficult to express otherwise.

To further this analysis, excerpts from literature on silence, and on related subjects are incorporated. There is pertinent research on topics like non-verbal interaction, empathy, and listening and I have drawn on this literature to augment a description of the dialogue of silence. Together, the narratives, poems, and literature provide an understanding of how silence is used in exceptional nursing practice.

LEARNING TO USE SILENCE

Among the nurses I studied there was agreement that, "you grow into the use of silence," and that it is "a very powerful and advanced skill." These nurses confirmed that they do consciously use silence in their nursing care, but this had not always been so. Early in their nursing careers many talked about trying hard to "say the right thing" to patients and their family members. Jane phrased it this way, "I found that I used to worry a lot about saying the right thing. I have discovered that the `right thing' often means saying nothing at all."

Although these exceptionally competent nurses agreed that silence is useful and effective in conveying concern for patients and in allowing them an opportunity to express themselves, they acknowledge that it is difficult to do. Lana said,

> We are a very verbal society. We talk, talk, talk. We hardly ever stop to really listen. We generally don't like silence. It is very uncomfortable, and it was for me too, especially in the beginning. It's not that you don't want to be quiet, it's just that you can't, it's not natural, at least not for me anyway.

How did these nurses learn to practice silence effectively? They talked about observing other nurses using it with their patients. "It was just so amazing," commented Jane as she described a particular moment when a nurse she considered very capable calmed an agitated patient without a word by placing a quiet hand on his shoulder. Other nurses described how they discovered the power of silence on their own, often quite by accident. Jane told me of this experience.

> I was with this patient I didn't know very well. His doctor just came in his room on rounds one day and said, "Your cancer has spread. There is very little else we can do for you. It doesn't look good," and left. I was blown away. Because I didn't know what to say, I just sat down on the edge of the bed and the patient and I sat there looking out the window together. I just couldn't think of a thing to say that would counter the intensity of what had been said, or make the patient feel any better. Finally, I just left.
>
> A few days later that patient said, "Thanks for being there when I needed you." I learned something really important from that experience.

A LESSON LEARNED

There is a time to be silent,
and a time to speak.

The key is,
learning to tell the difference,
and having the temperance
to do what's right.

Part of learning to use silence, is learning to hear differences in silences. O'Banion and O'Connell (1970) explain, "Sometimes silence means that a great deal of suffering is present. Embarrassing circumstances may cause silence. Exhaustion may bring a peaceful kind of silence" (p. 83). Moria, one of the participants, talked of these differences when she commented, "I try to be tuned in to the variance in silent human sounds." Blondis and Jackson (1982) contend, "In silence people may express feelings ranging from empathy and love to resentment and hostility" (p. 18). They add, "Silence does have range, and when this is understood it becomes less threatening" (p. 18).

TIMES WHEN SILENCE IS USEFUL

It appeared that the exceptional nurses studied used silence in a variety of situations. In particular, when there was nothing more to be said, when communicating with patients across cultures, when their patients were dying, when their patients received bad news, when their patients were psychologically or cognitively impaired, when words were unnecessary, and when there were no right words. Examples of each of these applications are described in the following sections.

When It Has All Been Said

THE DAY THE WORDS RAN OUT

They have poured so freely
over the years,
like sand flowing through an hour-glass.

Then one day,
like the sand,
the words just all ran out.

But don't be tempted
to turn the hour-glass over,
to fill the void with endless chatter,
because no matter what you do,
the sand will never flow as smoothly again,
and we'll both just be disappointed.

Marie told me the following story that illustrates this particular use of silence.

> She was my patient, but more than that we had become friends over the six years. She had come to the hospital for treatments, pain control, and now for palliative care. We had shared so much: laughter, pain, and true accomplishments. I remember how excited I felt when she was rehabilitated from major back surgery. She was able to walk again. Sure she had to use a cane, but she was travelling.... It was a miracle, and we celebrated!
>
> Now, those were only memories as she was admitted for palliative care. I enjoyed being her nurse as we shared a lot about one another's lives. She knew of my hopes, dreams, and plans. I knew of her favorite things, her tears, and her troubles. It was Christmas, and she was assigned to me. She struggled to speak as it now required a great deal of effort. So now, I also spoke very little. She slept and dozed off frequently as the narcotics were being increased daily. When she would open her eyes, we'd smile. I remember clutching her hand just before I left my shift and holding that grip. I wished her a beautiful Christmas; peace was my greatest hope for her.
>
> I left the room. I remember wanting to go back to her and hesitating. Should I say "good-bye?" I didn't return. Over the years we had said a lot. The last day we said little and I still feel that was all that was needed. Silence speaks in gentler ways than words at times.

In a follow-up conversation with Marie she reflected on her story saying,

> Sometimes everything that needed to be said has already been said. If it has already been done, you have to recognize that. I had been with Joan for six years. When it came to the end there was nothing left to say. We had said it all. The words had just run out.

THE SILENT PARTING

We have been together for a season,
and our time has been so good.
When it's time for me to go,
just place a finger to your lips
and step away.

There are no words - no adieu,
no farewell, no good-bye,
that can say anything
that we haven't already said;
that can mean anymore
than you already mean to me.

When Communicating Across Cultures

In some cultures silence is a more accepted and therefore a more appropriate means of communication. During one of our conversations Marie recalled this memory of a young native boy she had cared for.

> He was a young guy, a native Indian from Northern Alberta. He just didn't use many words. It wasn't his way. I knew that talking would be too much for him. It wasn't needed. When I watched his family around him, especially his Mom whom he loved very much, they just were very quiet. They just sat with him. So when I was his nurse I tried to mirror my behavior to theirs, although I was still me. I thought that would show respect for the ground he stood on, for his culture, his ways.... You have to be able to do that and not detract from your personality and become someone you are not. It's a real art.

Jane's story tells of a man from a different sub-culture of society and his silent approach to communication.

> One elderly fellow I will always remember. He was a hermit; he lived in the mountains. Everyday he would get up at 4:30 A.M. I would find him up in the lounge just sitting and smiling. The first time I saw him there I said, "You're up...why can't you sleep? Do you have pain? Would you like some warm milk? Shall I have the doctor order you a sleeping pill?" He just said politely, "No, no, no, no, I always get up early at home. You know the birds sing their best songs in the

> morning."
>
> I just let him go with his agenda. What was I going to do, put him back to bed? He was 88 years old, and he had seen many early mornings.
>
> I remember him because he wasn't a man of many words. I just sat with him. We both knew darn well there weren't any birds to hear, but we just sat there listening.
>
> I just sat with him.... We didn't talk much. I thought if I had been living alone all those years I wouldn't have much to say either. I just knew it was a great morning start for him. What I think he meant was you do your best in the morning.

REFLECTIVE SILENCE

Meet my silence with silence.
Reflect my ways with your own.
See the me that I am,
not the me that you want me to be.
Sit with me
and let the silent notes of the birds' songs
sing to us.

When the Patient is Dying

Patients in the final stages of their disease are often most comfortable in an environment that provides limited stimulation, including a reduced noise level. Mindy confirmed this when she stated,

> In the end their cognition and ability to perceive things around them is limited, or they may become hypersensitive to the softest sound. All they need is the sense that someone is there, so just being there and touching them is the best nursing care you can give.

Dying patients often seem appreciative of silence. Blondis and Jackson (1982) suggest that silence gives patients "time to evaluate" (p. 42), and it allows them to focus without disruption. An important part of preparing to die is life-review, a reflection, an evaluation of one's life. This may be accomplished best in an environment that is quiet and free of distractions.

When the News is Bad

Throughout the course of their disease, cancer patients may receive news that is distressing. Diagnostic test results that show the tumor has returned or reports that the treatment has not been effective can be emotionally devastating. In these instances silence was often seen by the nurses studied as the most adequate nursing intervention.

While commenting about such situations Jane advised, "They wouldn't understand your words, but they do understand your silence." This view was echoed by a colleague Moria who said, "When something is too overwhelming, silence and touch are the only things that make sense." Marie commented, "When my patients get really bad news, something that just shatters them, I just sit with them and hold them. Anything that I can think to say at a time like that won't make it better. It's just too bad to be made better."

SILENT SUPPORT

Your words are lost
in a sea of confusion and pain.
They are not lifeboats for me,
they are like icebergs jamming me, ramming me,
pushing me under again, and again,
until I can't breath.

Stop! Please stop.
Just stay with me and share my pain.

When Patients are Psychologically or Cognitively Impaired

Patients with cancer frequently have cognitive or psychological barriers that inhibit verbal communication. One field note reads,

> Mindy has to be so skilled at alternative forms of communication. Today, none of her three patients could communicate through speech. One is deaf, one only speaks Croation, and one is heavily sedated and cognitively impaired by medication. Silent exchanges combined with touch were her only means of communicating important and complex messages to each of them.

Patients who are cognitively impaired or psychologically traumatized may take longer to respond to questions or statements from the nurse. Blondis and Jackson (1982) write, "Silence invites response and gives patients time to formulate an answer" (p. 42). The nurses I observed were sensitive to this. Julie told me, "With sick people you have to wait long enough to get a response.... If you are willing and able to wait you just might find out something important, but first you have to be comfortable with silence." This was supported by Jane who commented, "I use silence. It gives patients psychological space to think, to change their minds."

For patients in denial silence is very important. This is the story of a moment observed.

> Sitting and staring at the T.V. was an attractive woman, probably about 30 years old, although it was hard for me to tell because she had lost all of her hair. When we entered her room, her gaze remained fixed on Oprah. The nurse walked up to her and sat down next to her. Without forcing eye-contact, the nurse said, "Leigh-Ann, would you like to talk?" As the nurse sat waiting for a response, Leigh-Ann turned to her and in an angry outburst said, "There must be some mistake, it can't be

> me. This isn't happening. You must have the wrong person." Quickly the anger gave way to waves of sobs as the patient collapsed back into her chair. The nurse said nothing. In staying close and silent, she neither reinforced the denial nor impinged on the patient's need for it.

Blondis and Jackson (1982) explain how silence can be used to respond to a patient in denial. They recommend that, "you let your silence say, `I am here, I will help you in any way I can. You are not alone.'" (p. 42).

When Words are Unnecessary

The nurses all described incidents in their practice where words were unnecessary. At times like these, they knew what their patients were thinking, or what they needed from them without being told verbally. This story, written by Marie, is an example of one of these situations.

> Mimi was an exotic looking Egyptian lady in her mid-twenties. A mother of three, she was a mere imprint of her former self. Mimi was suffering from the "silent killer," ovarian cancer. A bowel obstruction prevented her from eating and she was being kept alive with intravenous nutrition. No further treatments aimed at curing her disease were planned.
>
> Her youngest child was a year old. The room was dim, as the curtains were drawn. Her children were playing in the room away in a corner. I sat on her bed as she had called and asked me to come to her. The family members brought the baby to her. Mimi turned and looked at me. "Please take her" she said, pushing the baby towards me.
>
> At first I was puzzled by her request, but soon I knew what was happening. I eagerly took the child and held her close to me. Mimi had begun to draw away from those she loved most. She would soon begin her new journey, the end was near. Yet she wanted to see that her loved ones would still be cared for after she was gone. My accepting her baby reassured her of this in a symbolic way.
>
> I felt very special that she called me and asked me to take her baby. I will always remember her. I didn't talk to her about that request. I knew what was

> happening, if only sub-consciously. Silence was all that was needed. It gave her permission to separate, for now she was journeying alone.

SILENCE IS FOREVER

Words are for now;
silence is for eternity.

When There are No Right Words

Sometimes there are no words available that will be the right words. When this happens, the nurses in the study relied on silence. This story is an example of such a situation.

> Code one, one, one. My patient. My room. It was 0200 hours and staffing was minimal. My heart was pounding, adrenaline pumping. It was my patient who had arrested.
>
> Fortunately the cardiac response was strong and the arrest was primarily respiratory. He was in stable condition within 45 minutes of the beginning of C.P.R. I would give him one-to-one nursing care for the reminder of the night.
>
> The next day I went to see him, as I felt I should share with him some of my thoughts during the code. I told him that I was very frightened that we might have lost him and that I was glad that he responded so well. He revealed that he was very much aware of our presence during the code.... Then he pulled out a very carefully folded letter he had written his adult son. It contained instructions that he should not be resuscitated should this happen again.
>
> Tears dripped slowly down his cheeks as he read it to me. I listened intently for this was a very precious "sharing" gift to me. When he finished we enjoyed a few moments of quiet togetherness. No verbal response was needed.

UNSPOKEN WORDS

The most powerful words
in the human language
may be those that are never said.

THE GIFTS OF SILENCE

When a nurse is able to use silence effectively the patients and nurses benefit in several ways. These benefits I called the gifts of silence. Two that are described in the following section are the gift of being present and the gift of listening with openness.

Being Present

THE GIFTS OF SILENCE

With my silence I give you everything,
permission to cry,
to laugh,
to be silent too.

What does it mean to be present, to really be there for the patient? The literature promotes "presencing," or "being with" as one means by which nurses can assure patients they care about them. Bottorff (1991a) states, "There is something in the `being with' that reveals the nurse's feeling with the other, regard for the other as a person, and desire for the other's well-being" (p. 244). Clayton, Murray, Horner, and Grene (1991) claim that presencing is a part of establishing a connection between nurse and patient. To Watson (1989) being present is an expression of the nurse's participation in the patient's experience. Watson states that, "Human presence may in some ways directly and or indirectly restore the human-centered subjectivity and dignity of both the care provider and care receiver" (1989, p. 129). In keeping with this view, Blondis and Jackson (1982) add that unsolicited time spent with a patient demonstrates commitment to them.

Presencing is more than just being physically present. Marcel (1969) distinguishes between physical presence and being truly present.

> There are some people who reveal themselves as "present," that is to say at our disposal, when we are in pain or need to confide in someone, while there are other people who do not give this feeling, however great is their good will.... The most attentive and the most conscientious listener may give me the impression of not being present; he gives me nothing, he cannot make room for me in himself.... The truth is that there is a way of listening which is a way of giving, and another way of listening which is a way of refusing.... Presence is something which reveals itself immediately and unmistakably in a look, a smile,...or a handshake. (pp. 25-26)

For Marcel (1969) being present is communicated in part through silent measures: listening, looking, smiling, and touching. As Green-Hermandez (1991) states, "Being there does not need to be verbally stated in order to be felt" (p. 120). It is more than sitting or standing beside someone, or saying "I'm here for you," it involves an overlapping of selves, or as Watson (1989) describes it, it is a "human-to-human connectedness" where each is touched by the "human center" of the other.

The nurses I interviewed talked about being there for their patients. Jane commented,

> The best way you can let your patients know you are there for them is by giving them silence. Staying with them through the silence tells them that you have time for them, that they are important to you, more important than anything else at that moment. If it's quiet, and there are no more questions and no more answers required and you still stay with them, it tells them a lot. In our culture a lull in the conversation is a chance to leave, to physically remove yourself. If that break comes and the patient finds you still there, they know you really want to be with them.

Marie simply said, "You can really be present when you are silent."

According to Gendron (1988) being present with a patient is a choice made by the nurse. In her opinion one must engage in self-discipline to gain skill in quieting and focusing one's self in order to be truly present for others. While the nurse may be concerned with fleeting time and tasks to be accomplished, the client is focussed on the moment (Mackay, Hughes, & Carver, 1990, p. 83). To be effective the nurse needs to attend to what is important to the patients, their here and now experience.

What does being there do for the patient? Green-Hermandez (1991) suggests that it makes patients feel emotionally and physically safe. The following field note demonstrates this.

> Her patient tonight can't talk. Each breath is a struggle. He is so afraid that the next breath just won't be there. In his eyes I see an unmistakable look of panic. A laryngeal cancer and tracheostomy have taken his vocal cords and a tonsillar tumor has impaired his hearing. How can she let him know that she is there, that she cares? She doesn't say a word. As she stokes his hair, her eyes tell him what he so desperately wants to hear: that she is with him, that she will stay, that she will watch over him. Gradually, silently, he drifts off to sleep.

Bottorff (1991a) agrees with this view. She writes,

> When a nurse is with us, in the sense of being present, we feel the security of her protective gaze, we feel valued as a person, the focus of her attention... We sense the nurse is close enough to feel with us, sharing the loss that accompanies the dis-ease we are experiencing in a sensitive, intimate way.... She understands. When a nurse is truly present, seeing and feeling all these things, we sense a kind of hopefulness.... For a moment, we are not alone.

(pp. 244-245)

A story written by Julie illustrates the power of silent presence.

> My first encounter with Paul was on the phone. He had heard about palliative care but wanted to clarify a few things. I could hear young children playing happily in the background. I explained about symptom management, admission criteria, etc. I thought perhaps he had an ill parent. Who knows, maybe he was a reporter, a philanthropist, or maybe he wanted to volunteer? His questions were well prepared and specific. The closest I could get to asking, "Why do you want to know this anyway?" without feeling I had intruded, was saying, "We are here to help. Please feel free to call back if we can be of any further assistance."
>
> Some weeks later a Paul was admitted to room 6. The door was always shut, his wife and his two children visited daily. He was waiting to die. He withdrew from everyone.
>
> I could almost guarantee that when I was on he would be part of my assignment as the other nurses find this kind of patient frustrating. It seems no matter what you give, nothing comes back.
>
> Finally one day in sheer desperation, I heard myself saying, "Paul, this is Julie your nurse. Yes, I'm your nurse again today. And I know this isn't fair but you're just going to have to put up with me. You see I am your nurse and you deserve just as much time as any of my other patients."
>
> As the scenario evolved, I spent time with him. Sometimes I would read to him, mostly we would just be together.
>
> In one way, he was still waiting for the promised miracle. One day we did discuss the whole thing of miracles. Yes, there was a miracle there, it wasn't the one he had hoped for, but it was there nevertheless. We celebrated his daughter's fourth and son's first birthday on the unit. It was clear as the days passed that this little boy was his Dad's miracle. The spitting physical image of his Dad, he learned to walk in our long hallway. Both kids and Dad would take over our jacuzzi tub with mountains and mountains of bubbles (Yes, they do plug the jets and you have to call maintenance to fix it!). You see that little boy was conceived after Paul's diagnosis and was born with the astrological sign of Cancer. The odds said that Paul

> should have never seen his child born, never mind walk, say "Daddy," or demonstrate his Dad's incredible shyness.
>
> Paul continued to be "my patient." The door was still closed most of the time and we still spent a lot of our time together without exchanging many words. But one day, I will never forget as long as I have the privilege of living. I opened his door, not really knowing what I was going to encounter that day, to see him lying there with a single yellow rose in his hand and a card that said, "For Julie." We didn't say anything, we just hugged. I came out of that room and totally lost it. I don't usually hesitate to share tears with my patients, but for some reason, that day, I really lost it. The sheer intensity of that moment, even as I write it down, still makes me cry.

BREAKING THROUGH

Words, words, words,
jackhammers pounding
against my protective wall of isolation.

They do not crack it.

Gentle, silent presence
passes through the wall,
and dismantles it,
without even leaving a mess.

Listening with Openness

Silence is important for listening and for hearing the message. As Blondis and Jackson (1982) point out, you must be silent if you wish to listen to another, to listen with openness. Listening with openness involves silencing not only your mouth, but also your mind. Only if you are silent in these ways can you receive and give the gift of listening with openness.

Blondis and Jackson (1982) maintain, "Good listening is an essential ingredient for providing nursing care of good quality" (p. 2). Maureen agreed saying, "Listening, listening is the biggest part of nursing. You need to be an active listener. The best nurses are the best listeners." She then went on to recall a specific incident when, she believes, that really listening was all a patient needed from her.

> Dani was a 32 year old woman who should have had the rest of her life ahead of her. She was married and had two young children, one four, and one six months old. During her most recent pregnancy she had noticed a change in a mole above her right eye. The surgical removal of the mole had been unsuccessful and the wide-spread metastases were diagnosed quickly after that. She developed a cord compression which didn't respond to radiation therapy, so she could no longer walk.
>
> This particular incident occurred during her final admission. I was working nights and I had just finished my 0300 hour round. I entered Dani's room to find her wide awake staring out the window. I walked up to her and asked if she was having trouble sleeping. She said that she had been lying awake thinking about life and what she had accomplished. I asked her if she would like me to stay and sit with her awhile. She accepted, telling me how frightening nights could be. I put down her side-rail and pulled up a nearby chair. I laid my hand on top of hers and for an hour I sat and listened to her. She told me how she had met her husband, about her university years, her brief career, her adventure in Europe, and finally about her two children. Her biggest regret was that she wouldn't be able to see them grow up. After she shared this with me she seemed to relax. I started gently stroking her forehead and she finally slept.

LISTENING WITH OPENNESS

As I listen to you speak,
my ears catch the sound,
but my heart absorbs the message,
and I allow myself to be changed by your words.

In this way,
listening is a gift to you,
but it is equally a gift to me.

Blondis and Jackson (1982) contend that a common way we communicate understanding is by listening, not passively but actively, letting the person know they are being attended to, heard, and understood. They explain that nurses have to be able to let their patients know that both the factual and the emotional content of what was communicated have been heard. O'Banion and O'Connell (1970) describe this as "the kind of listening which actively seeks the other's feelings" (p. 21). Succinctly stated, effective listeners are people who use silence with as much eagerness as they use talk (Blondis & Jackson, 1982).

As Blondis and Jackson (1982) point out, one way to accomplish this is by asking questions that encourage the patient to continue or elaborate and then remaining quiet while they answer fully. In Hogan's view, the silence indicates compassion, acceptance, and support, as well as a willingness to be part of the patient's experience (1976).

O'Banion and O' Connell (1970) provide a sensitive account of listening with openness.

> All of me that I am in touch with and can command is directed toward you, what you are saying. All the facets of my being that feel are ready to receive your feelings. I begin to feel the struggle of your wanting to share with me; not being me, not trusting me, not knowing if I understand what it is you want to share. I feel your struggle and offer support. I want to understand. I know this is not easy for you. I lean toward you, I am ready to hear and feel, I am to be trusted. You share more, I do not retreat. I seem to want to understand. I seem to know what you are feeling. The pain grows strong and the tears relieve the pressure inside. I do not run away, I move closer, I touch a tear and say, "What do these mean?" Your pain touches the feeling of my pain and I respond with like pain. We share tears. I care for you. (p. 161)

THE DIFFERENCE

When I hear - I hear.
When I listen - I feel.
I make room in myself for you.

FORMS OF SILENCE

In observing the nurses it was possible to identify several different forms of silence. Specifically, non-verbal messages framed in silence, silent messages encoded in words, and silent messages encoded in actions. Each of these forms is described in turn in the following paragraphs.

Non-verbal Messages Framed in Silence

Barnlund (1990) describes non-verbal behavior as "an elaborate code that is written no where, known by none, and understood by all." Blondis and Jackson, (1982) contend that non-verbal communication is a "two-way mime performed on the stage of the unconscious conveying messages that are only partially transmitted verbally" (p. viii).

Kagen, Evans, and Kay (1986) provide a more unambiguous definition of non-verbal behavior suggesting that it is "anything about social performance that is not speech" (p. 44). This can include gestures and movements, facial expressions, proximity, touch, self-touching, gaze, posture, gait, dress, accessories, and emblems (p. 48). These researchers specify that certain non-verbal responses such as close proximity, prolonged eye contact, touch, and a calm soothing voice can reassure the patient.

During my time in the cancer unit I made the observation that non-verbal gestures may be accompanied by words but that the real message that is being communicated non-verbally is almost always framed in silence. The nurses seemed aware of this and trusted the silent non-verbal messages above their patients verbal responses.

The following is a moment I observed. The nurse in this case, Julie, was sensitive to the non-verbal message being sent by the patient's mother. Although the message was subtle and could have been easily misinterpreted or ignored, the nurse recognized it as a significant moment and captured the opportunity to help this mother.

> The mom of an 18 year old girl with a brain tumor was standing outside her daughter's room, staring at the coffee maker, fumbling with her cup, and apparently about to pour herself a drink. The nurse I was observing, Julie, walked up to her and said, "You need a hug." She gave the mom an extended bear hug and without further words guided her to a private corner of the unit where they sat and talked.
>
> Her daughter, the patient, had just told her mom that when she died she would go to heaven and be a star shining down on everyone. This image had been too much for the woman to bear. After Julie talked to the mom she was able to go back into the room and be with her daughter.

When I asked Julie about this encounter, she said, "Didn't you see the look in her eyes, and the way she was standing. She didn't want any coffee, she just couldn't bring herself to go back in the room. I could just tell she was ready to break." Julie had detected the non-verbal message framed in this family member's silence.

Silent Messages Encoded in Words

There were times during my observations when I saw the nurse's seek, find, and decode silent messages, requests, and pleas from the patients that were encoded in words that, on the surface, carried a completely different meaning. Blondis and Jackson (1982) suggest that delivery of high quality care depends on understanding patient's needs...many of which are expressed indirectly.

On one occasion a patient rang her bell and as we entered the room the distressed woman said, "The baby won't settle and needs a little pat. Bring the baby here and I will give him a rub." As I looked around the room for a non-existent baby, the nurse, after pausing for a moment, turned the patient onto her side and gave her a back-rub. Leaving a very content patient the nurse said to me, "I understood what she meant. She just needed a little attention herself." This same patient had been labelled as "confused" by some other staff members.

I agree with Blondis and Jackson (1982) who say that sharp, accurate perception is a necessary ingredient of meaningful patient care. An exceptional nurse is discerning, knows the patients well, and is able to anticipate their needs by reading the silent messages in their words. For example, Julie told me,

> What the patients say, isn't always what they mean. Yesterday, I offered a patient a back rub. She said, "No, I'm O.K." I just knew that she didn't want to say no. She really would have liked to say yes, but she didn't want to bother me or take any of my time. So I said, "Of course you are O.K., but how about a treat." A big smile came across her face and I gave her the rub. We both felt good about it.

HOLOGRAM OF LIFE

Hidden in our everyday conversations,
are the things we would like to say
if we only had the courage.

To fulfill their nursing responsibilities messages need to be communicated between nurse and patient. In an environment that is frequently emotionally laden some of these messages that should be communicated are difficult to say. As a result, the encoding of messages in safe words occurs. This is an indirect way of saying what needs to be said. It happens in conversation initiated by either the nurse of the patient. For example, Mindy called the son of a patient whose condition had deteriorated and said, "Your Dad's not able to be up at all today. He can't recognize any of us, and his breathing is poor." Translated this means, "Your Dad's probably dying. Please come quickly." I asked the nurse about this conversation and she explained it this way.

> In a situation like this, I usually try the gentle approach at first. If it doesn't work, if they just don't get it, I become as direct as I need to be to get my patient's needs met. I think the more subtle angle is good because it gives the person you are talking to a chance to come to the sad realization on their own. It's not forced on them. It's not so harsh, it's just more human somehow. But it is still honest, not just as directly honest.

The following is Jane's story about a patient's encoded message for her.

> It had been a very long day. I had six patients, all requiring complete care so I was really tired. Mrs. Marshall was particularly time consuming. She had cancer of the cervix that had spread throughout her abdomen. The draining fistulas around her groin area

> necessitated frequent dressing and linen changes. It was close to the end of my shift and as I changed her bed and tucked her in I managed a quick "bye" and hurried out of the room anxious to go home. She called after me "Thank-you Jane. Take care of yourself." I replied, "O.K., I will," and rushed down the hallway.
>
> After I'd taken about 20 steps I stopped. Something was wrong. It wasn't what she had said, it was how she said it. Mrs. Marshall was trying to tell me something.
>
> I went back to her side, took her hand and said, "You're saying good-bye, aren't you." She said that she knew her death was near and that she wouldn't see me again but she wanted me to know how much my care had meant to her. I thanked her too for all that she had taught me about life and death. Then we said a proper good-bye.
>
> The next morning when I went to her room it was empty. I would have been so sad if I hadn't heard her message.

HIDE-AND-SEEK

Like children in the garden,
we play hide-and-seek with our words.
I hide, you seek.
You seek, I hide.
Back and forth we go.

Why do we play this game?
We really have no choice.
We need a cushion, a cloud around our words.
It keeps them from bumping into our emotions,
and breaking them to bits.

Silent Messages Encoded in Actions

Mindy recounted situations in which she believed her actions transmitted powerful messages to her patients and the family members. In Mindy's estimation, silent messages can be encoded in nursing actions that communicate meaning more adequately than words can. Mindy said,

> Sometimes what the nurse does and how she does it communicates so much to the patient and family. When a patient is close to death for example, the family focuses on the small physical things like uncut toenails, uncombed hair, or wax in the ears. I make sure these things are all taken care of. It doesn't do much for the patient, but it reassures the family that

> all that can be done is being done and that I care about the patient.

In our conversations the nurses often referred to the importance of how they perform their work. They talked about the being confident in their actions, meeting the patient's needs quickly, keeping the work environment neat, and keeping "inappropriate" staff behavior out of the sight of patients. The major reason for this concern about how the care is delivered is summed up in Lana's comment.

> The patients and their families are always watching us. They determine how good we are, by how we do things. How you do your work tells them a lot. They don't know if you are doing a procedure correctly or not, but they do know if you are working confidently. We want them to have confidence in us. We have to show them by how we meet their needs that they can trust us. That they matter to us.

Another nurse, Peter said, "Doing the little things like folding their pyjamas and putting them away in the morning, remembering to warm up their milk if they like it that way, bringing them two different flavors of jam to choose from...it might seem trivial, but it is critical."

This field note describes a scene that was an example of Peter and his colleague being mindful of the small details in their care and the message this communicates.

> The patient is a very elderly Chinese lady. She is unable to speak or understand English. Today she is dying. They tend to her often, making sure she is comfortable. They select the prettiest night-gown from the hospital collection, a blue flowered one that complements her complexion. They choose one with long sleeves (because she is always cold). Every time they turn her, her hair is combed, her mouth and eyes are moistened. She is too weak to drink from a straw, so a few droplets of water are gently placed on her tongue. All of these actions are done with such gentleness. Their hands don't make a sound as they move from task

to task.

During a conversation Marie made this comment.

> I try to make my patients feel like they are the most important people in the world to me for the moments that I am with them. That has been my goal. It's the little things that make a patient feel important, like the way you enter a room is important. I consciously slow down my pace as I go through their doorway. I attend to their needs in short order, not waiting to be reminded. If I can I anticipate their wants, like an extra pillow or a glass of juice. It makes a big difference to them. What I do and how I do it tells them so much.

Julie talked about the importance of another silent action, keeping promises made to the patients.

> I try to always keep promises. If I say I'll be by to make their bed at 1000 hours, then I'm there at 1000 hours, not five minutes after. If I get busy, I stop by and tell them I will be delayed.... It tells them that they are important to me.

In all of these examples, the nurses are transmitting silent messages to the patients, messages that are encoded in their actions. The nurse's actions are observable by the patients, their interpretation of these actions may affect the nurse patient relationship in many ways.

Because nursing work involves two-way communication, patients also transmit silent message in their actions. Mindy told me this story about an elderly Russian gentleman.

> He couldn't speak a word of English. I had just finished making him a cup of tea because he loved tea with breakfast and the kitchen staff always sent him coffee. When I brought him his cup he didn't say anything, he just reached right up and kissed me.

THE KISS

When you meet my needs
you tell me that you care for me.
That even though I'm old and sick

I still have value,
I still have worth.

I kiss you.
It's the only way I have to say
I treasure what you do for me.
You keep me whole.

This example, like many of the others in this chapter, illustrates the two-way nature of silent communication. Silence is used by both the patients and the nurses during their encounters. In this way it is a dialogue of silence.

CHAPTER SUMMARY

From this discussion several summary statements can be made. First, it appears silence is a skill that is learned by the nurses largely through their experiences and by observing other nurses who use it effectively.

Second, the exceptionally competent nurses found silence appropriate in a variety of circumstances. Specifically, when all that needed to be spoken had been said, when caring for patients from different cultures, when the patient received bad news, when caring for cognitively or psychologically impaired patients, when caring for dying patients, in situations where words were unnecessary, and at times when there were no suitable words available.

Third, silence shared with patients provides them with multiple benefits or gifts. Two gifts discussed in this chapter are the gift of being present, and the gift of listening with openness. Being present furnishes patients with a sense of emotional and physical safety, and a feeling that they are valued, understood, and not alone. Listening with openness means the nurse listens with both verbal and mental silence prepared to receive the patient's messages and remaining open to being changed by this communication.

Fourth, the silent dialogue between patient and nurse takes a variety of forms. This chapter provides examples of non-verbal messages framed in silence, silent messages encoded in words, and silent messages encoded in actions.

Finally, while silence is helpful to patients, it also is beneficial in many ways to the nurses. For example, it allows nurses time to think, to reflect, to live through the moment. Although it is of apparent worth to all parties, silence is rare in health care institutions, largely because of environmental factors. In my journal I wrote, "In the face of this almost constant stimulation of sounds, when silence occurs, both the patients and the nurses seem grateful."

REFLECTIONS ON THE DIALOGUE OF SILENCE

As a reflective summary each of the qualities of silence suggested in the opening sentence of this chapter, purity, precision, and perfection are discussed in the following sections.

The Purity of Silence

Blondis and Jackson (1982) explain that "Words are often not what they seem and are sometimes used to camouflage what is actually felt" (p. 42). From the observations and interviews, as well as my past experience, it appears that silence provides the purest form of communication.

Wordless messages are not likely to be interpreted in any way by the sender before they are sent. When we use words to communicate, we are in a sense often analyzing our own thoughts before sending them. To put a feeling into words, we usually first think of what we are trying to say and then of how it can be phrased. We may decide to couch, or limit the expression of our true emotions, needs, or thoughts by the words we choose. However, when we send a message in silence it is uncontaminated by words that are open to misinterpretation by the receiver, or limitation by the sender.

Silence does not have to be used alone. It is often combined with other non-verbal and verbal forms of communication. Doing so does not diminish its purity. Sometimes this potentiates its effectiveness, such as when silence is combined with appropriate touch. At other times silence is best left unadulterated and untreated, just whole and real.

Silence is Precise

If we were to depend on words alone to communicate our needs, fears, hopes, and feelings, not only would our communication be susceptible to inaccuracies, it would be slow. Words are often not efficient, they may be imprecise and awkward. It frequently takes many words to convey a single emotion, and then, when one's feelings are put into words, they can be misinterpreted.

Alternately, a silent moment can convey a myriad of emotions, precisely, quickly, and accurately. Jane, one of the nurses in this study, in analyzing a narrative she had written said, "Silence is more filled with communication than words can ever be."

Not only are words often inadequate and lacking in precision, they can be destructive to the nurse-patient relationship. Phrases like, "it will be O.K.," "I know how you feel," and "don't worry" are not only ineffective, they can convey a message that is the antithesis of what the words are meant to say. When we were discussing this notion Moria commented,

> When I'm tempted to say something like, "You'll be fine" an alarm goes off in my head and I just shut-up. Saying, "You'll be fine" is like saying, "I really don't care about you or your situation. I'm uncomfortable with you sharing your feelings with me. I don't know how to answer you. Please stop talking." It doesn't do the patient any good at all. You are better off saying nothing.

SHARPENED WORDS

Words between us are few.
But the words we do share,
these words are like arrows,
sharpened by the silence.

Blondis and Jackson (1982) provide a succinct summary of how a nurse's actions without words can communicate with great precision.

> It does not take a lot of words to tell the patient you really care. You tell them best by going directly to them as you enter the room, staying close to them,

> physically touching them, and asking them with your eyes what their needs are. (p. 170)

Silence is Perfect

Silence is a vessel for carrying messages. It is limitless in capacity, and nearly always free of defects. In silent messages there is little of the message lost. The silent meaning goes by a direct route, from the mind of the sender to the mind of the receiver. It is not filtered first through a mesh of imprecise words. Although non-verbal gestures can be deliberately preformed and are open to misinterpretation, I believe that silence is largely exempt from these frailties. Silence takes non-verbal communication to a higher level of interpersonal exchange.

Silence is especially effective for transmitting feelings, emotions, things that we do not have words for. Hogan (1976), for example, explains this stating that compassion, acceptance, and support are communicated best by silence. In an emotionally laden environment these communications are frequently necessary and often the words we have available are too limited to communicate such subtle and intense meanings and messages.

Blondis and Jackson (1982) indicate that "when silence is used constructively, the nurses can have stronger ties with their patients" (p. 19). Physiologically, psychologically, and spiritually there are times when patients need silence. If the nurses can recognize these times they can be very effective care-givers. Silence gives patients, their families, and the nurses what they are often lacking in the very public environment of a hospital: privacy and psychological space.

I believe that in silent moments the spirits of both the patient and the nurse can be nurtured. Perhaps perfect silence can be the ultimate encounter between nurse and patient, as Watson (1989) suggests an opportunity for the restoration of the human dignity of both the care-provider and the care-receiver.

Taylor (1991) writes, "Silence is not void, but productive...silence rings" (p. 353). Caputo (1978) in like vein asserts that to "hear what is spoken in silence all voices and sounds must be put away and a pure stillness must be there, a still silence" (p. 117).

Such silence is crisp, clear, and pristine. Creating a space where stillness can be found provides an atmosphere were patients are listened to and understood, where messages are sent and received unblemished by the static of the airways. For this to happen, the nurse must have the self-discipline, combined with awareness of self and situation, to remain appropriately silent.

Jane shared this story of her discovery of the impeccability of silence.

> It was such a cold February day. My patient had just died. The family hadn't made it in time. I felt so sorry that I did not call them sooner. As they arrived on the elevator, I greeted them without words and took them to the bedside. We stood huddled together in silence. I remember thinking at the time, "My God, it's so quiet. This is so good. This is just what we need." In the privacy of our own thoughts, we were each able to come to a realization of the meaning of

the loss for each of us.

PERFECT SILENCE

Someday,

after we understand
the genetic code of all life-forms,
the components of all universes,
the intricacies of all human interactions,
we will understand and use silence.

Then,

for the second time
in the history of the human race,
we will have learned to fly.

Chapter 6

MUTUAL TOUCH

CHAPTER INTRODUCTION

This chapter develops the theme of mutual touch using field notes and the words of the exceptionally competent nurses. Again, poems combined with narrative comments are the methods of data analysis.

Included in the chapter is a discussion of the state of nursing research on touch. In this section Bottorff's (1992) research on touch and cancer patients is described and the five types of touch she identified are discussed. Watson's (1979) two broad categorizations of touch are also introduced.

In another section of this chapter, the importance of touch in health care is elaborated to provide some context for descriptions of eight types of touch identified during this study. Specifically, the eight types of touch described are: procedural touch, non-physical touch, talking touch, trigger touch, social touch, diagnostic touch, comforting touch, and the final touch.

The nature of touch is examined in this chapter under the following headings: what is touch, touch in our society, touch and culture, qualities of touch, the language of touch, and touch used with other mediums of communication. Reference is made throughout the chapter to literature on the utilization of touch in effective nursing care.

Defining Mutual Touch

The second theme I call mutual touch. Touch by its nature is reciprocal, it affects both the person initiating the touch and the person being touched. It is impossible to touch someone without also being touched yourself, therefore touch is a shared activity. As this opening poem suggests, perhaps both the nurse and the patient are affected when a touch occurs.

THE HUG

Arms entwined.
Warmth exchanged.
Heart beats felt.
Concern sensed.
Care given.
Care given.

Early in the observation phase of this study it became evident that touch was important in the care given by the exceptionally competent nurses. These care-providers used every opportunity to touch their patients in a spectrum of ways, in order to accomplish a variety of purposes. One field note reads,

> She often sits on the bed next to her patients, or she stands very close to their chairs. This physical closeness seems to create an air of familiarity. It makes their relationship close very quickly. With these nurses and their patients there is a sense of urgency.... They seem to be saying, "We might not have too long, let's cut through the formalities, let's not play games, let's invite each other in right away." Touch seems to be one way they make this connection.

After another day in the unit I recorded this observation related to the use of touch.

> It was by touching, by holding her hand, laying a cold cloth on her forehead, and rubbing her sore back, that the nurse communicated that she cared. All that she did with touch said how much she wanted to help.

THE STATE OF NURSING RESEARCH ON TOUCH

There has been considerable interest among nurse researchers in learning about the use of touch. However, this interest has not yet translated into complete understanding. McCorkle (1974) and Tough (1989), for example, both studied the physiologic effects of touch on patients. Studies like theirs attempted to correlate being touched with changes in pulse rate, blood pressure, skin temperature, and respiratory rate.

In 1974, McCorkle contended that the significance of touching is considerably more profound than had previously been understood. Our knowledge about the use of touch in nursing practice remains limited, as many of the research studies conducted have been quantitative in design and most have focused on infants, the elderly, or obstetrical patients.

A specific method for using touch, called "therapeutic touch" has been researched by Krieger (1975), Heidt (1981), and Quinn (1983), among others. These researchers also attempted scientific investigations of the effects of this type of touching procedure.

Watson (1979) was one of the first nurse researchers to describe types of nursing touch using qualitative methods. She concluded that there were two categories of touch used by nurses, instrumental and expressive touch.

Estabrooks (1987) and Bottorff (1992) investigated the touching behaviors of specialized groups of nurses, while Morse (1983) focused on theoretical concepts related to touch using an ethnoscientific approach.

From among these studies, the two most relevant to this research were those by Estabrooks (1987) and Bottorff (1992). Estabrooks interviewed ICU nurses about the kinds of touch they used in their practice. These nurses identified the importance of skin against skin contact, and the role that other non-verbal cues such as posture and voice have in delivery of nursing care. Her most noteworthy conclusion is that touch is more than physical contact and it cannot be entirely understood by identifying its components or dimensions. These findings point to the need for research that focuses on a description of touch behaviors in context rather than attempts to only isolate specific types of touch.

Bottorff (1992) studied nurses as they interacted with cancer patients. Using video-recorded nurse-patient encounters and interviews, Bottorff identified five different types of touch. The nurses studied primarily used task-oriented or working touch, although Bottorff also categorized other types of touch into social touch, touch that comforts, connecting touch, and orienting touch (Bottorff, 1992, pp. 120-121). She provided a more comprehensive description of these types of touch than had been furnished previously. Bottorff reports, "In particular, the use of connecting touch, orienting touch, and social touch had not [previously] been well recognized or described" (1992, p. 120).

In a 1991b article Bottorff states,

> Some aspects of touch and touching, such as understanding the meaning shared by nurses and patients as they experience touch, may not be observable.... It may be necessary to use other qualitative methods (e.g. open-ended interviews) in conjunction with observational methods to gain a more complete understanding of touch. (p. 321)

Bottorff (1991b) concludes, "Little is known with certainty regarding nurse-patient touch" (p. 333) and "the poor understanding of touch is due to our approach to studying it" (p. 331). She proposes that, "Changes are needed in the approaches used in the research on touch; in particular, increased use of the inductive approach is crucial to development of a more complex understanding of touch" (p. 333).

THE IMPORTANCE OF TOUCH IN HEALTH CARE

Naisbitt (1982) writes, "We must learn to balance the material wonders of technology with the spiritual demands of our human nature," (p. 40) because "when high tech and high touch are out of balance, dissonance results" (p. 44). Tough (1989) in agreement with this point of view adds, "Beyond technology nurses have much to offer patients, they can offer themselves as well as their hands" (p. 120).

Upon entering a hospital, people encounter an unfamiliar, aseptic environment. White-coat clad care-givers move swiftly about the maze of corridors. Steel wheeled chairs and stretchers clatter, and machines flash and beep. The alien odor of antiseptic solution drenches the air. Hospitalization is a frightening, disorienting, depersonalizing experience.

In such an environment, Watson points out, "The care-giver provides a human presence that touches another's mind or spirit" (1989, p. 130). Human touch becomes imperative. It restores the human element, telling patients in a concrete way there are caring people here. Expressing this view, Tough (1989) reports that people in hospitals need human touch to balance the highly technical environment. Gadow (1984) is of a similar mind and claims that touch can reach past the bureaucratic-technological system and scientific treatment, allowing the patient to reach out of the solitude of suffering.

Upon entering a hospital a patient's psychological well-being is threatened. There is depersonalization and sensory deprivation. The effect is anxiety-provoking. Gadow (1984) adds that anxiety is among the most common and strongest responses to hospitalization. This point is also made by Sims (1986) who explains that anxiety associated with the stress of hospitalization must be countered by intervention involving caring, touch, and human contact.

One branch of the healing community which has recognized the importance of touch is nursing. Montagu (1986) attributes the use of touch by nurses to two conditions. First, the majority of nurses are women, and second, nursing tasks often require that nurses are in close physical proximity to their patients. He concludes that nurses have been in a far better position to appreciate the importance of touching in the care of the patient, and therefore it has become a natural part of nursing. In agreement with Montagu, Bottorff (1991b) contends that touch is universal and basic to the nurse-patient relationship.

One of my field notes describes the liberal use of touch by an exceptional nurse.

> The use of touch is very evident. On entering the room of almost every patient, the nurse takes the patient's hand, or places a hand on their shoulder. The nurse almost always go the patient's face, instead of addressing a patient from the foot of the bed or the door way. Standing close, making physical contact, and talking directly to their patient is the most common position these nurses take.

Marie said, "Nursing is wonderful because you get to touch the patient." Another nurse Jane states, "Touch is a part that nurses provide in a different way than other care-givers. Doctors touch the patients because they have to. We touch the patients because we choose to."

The nature of the nurse-patient relationship is such that touching is both inescapable and acceptable. Touch is the most personal of our senses because it brings two human beings into physical contact. To carry out nursing procedures the nurse must move into the patient's personal space. Blondis and Jackson (1982) explain that everyone has this personal space "an invisible area that surrounds their body" (p. 17). This space, they claim, is dynamic and varies from person to person. Only by decreasing the physical distance and crossing into this area are the touching behaviors such as holding, hugging, grasping, and stroking possible (Blondis & Jackson, 1982, p. 17). The physical space of both the patient and the nurse overlap when one touches the other.

As Blondis and Jackson (1982) suggest, "When two people are very close physically...they are less likely to verbalize since touch conveys many of the messages that would be otherwise expressed verbally" (p. 17). Although it is understood that nurses move into the patient's physical space to provide care, the nurse must also be willing to accommodate the patients in their own space. A touch involves an overlapping of two people's area of private space. For it to be a meaningful touch, in which messages are communicated and received, there is usually unspoken agreement that they are both willing for this encounter to occur.

According to Weiss (1979) nurses have implicit permission to touch patients because of their role. Benner (1984) too emphasizes the unique role of nurses in that, "By their very position, nurses are asked different questions and looked to for different kinds of help than other professionals" (p. 165). Julie, one of the nurses interviewed expresses a similar view. She said, "Nursing invites you into places you would never go, across the barriers to people, holding their hands and being close."

The nurses' comments and stories reflected a belief in the importance of touch in nursing care. Jane states, "Touching is critical. Empathy, caring, love, and concern are all transferred through your eyes and hands." Another nurse - Lana - emphatically proclaimed, "Touching...I think it is necessary. I think it is mandatory." After a particularly demanding day, Moria commented, "I like to leave a bit of myself behind for my patients. I do that with my touches.... I hope that the feeling of being safe and cared about that I communicate to them with my touch lingers on after I have gone. I believe that it does." Still another nurse Mindy confided, "I have had a really good day when I have made a connection with a patient...feeling comfortable sitting on their bed or giving them a hug, touching them in some way."

THE NATURE OF TOUCH

In the following sections various aspects of touch are addressed in an attempt to bring the reader to a greater understanding of the nature of touch. Specific mention is made of the use of touch in our society, the culture specific influences on the use of touch, the qualities of touch, the language of touch, and the potential in combining touch with other mediums of communication.

What is Touch?

Touch is a powerful, sometimes disregarded, always complex, channel of interpersonal communication. McCorkle and Hollenback (1985) describe touching as a therapeutic event. They add, "It is not as simple as a mechanical procedure or a drug, because it is, above all, an act of communication" (p. 85). Watson (1985) contends that touch causes the dissolution of boundaries between two persons (p. 129). It is described by Tough (1989) as a conductor of messages, and by Montagu as capable of "soothing ruffled feelings, assuaging pain, relieving distress, giving reassurance, and making all the difference in the world" (1986, p. 282).

Benner (1984) goes further, describing touch as a conveyer of "messages as well as physical stimulation and comfort" (p. 64). She emphasizes that touch signifies an emotional involvement on the part of the nurse, a concern or caring for another. Watson (1985) agrees saying "Touch is concern made tangible...an expression of the nurse's participation in the patient's experience" (p. 129).

O'Banion and O'Connell (1970) claim that we struggle with putting into words that which seemingly lies beyond words. Because of this sense of helplessness with the language we turn to touch, the silent communication. Montagu (1986) supports O'Banion's and O'Connell's assessment adding that, "Touch is always individualized, the interpersonal communications effected through touch will tend to be significant in a way that verbal language cannot achieve" (p. 133).

Referring to the shared nature of touch, Montagu (1986) writes, "Touch differs from all other senses in that it always involves the presence, at once and inseparable, of the body we touch and our body with which we touch it" (p. 125). Touch is automatically reciprocal. A nurse cannot touch a patient, without also being touched. In this way the nurse and patient share the experience. Touch is a way to reassure another person that you are present in the fullest sense of the word.

The nurses in this research project when discussing their touching behaviors emphasized the importance of touch being genuine to be effective, to achieve this sense of being there for the patient. They said,

> The touching has to develop in time. When I touch someone or embrace them it has to be real for me too.
>
> It needs to be real. If it's phony forget it.
>
> It can't be forced. You have to be comfortable with it yourself first.

Touch in Society Today

Although there is agreement that touch is an important interpersonal method of communication, fundamentally necessary for development and maintenance of health, Montagu (1986) explains that it is increasingly being denied many people. In his words, "Cuddling, caressing, embracing, stoking, the basic human touches, are withheld from the majority of people in our society" (Montagu, 1986, p. 133).

When a person is sick, disfigured, and deformed from cancer and cancer treatments the withdrawal of human contact would seem even more likely. Withdrawal happens at a time when the benefits of touch are critically needed. Jane observed, "The elderly and dying especially hunger to be touched. Many of my patients when I offer them my hand they clasp it so tightly, like it is a life-line or some treasure they are guarding. Sometimes they even reach for me before I reach for them." Mindy said, "Touch seems especially important for the elderly patients.... Their hearing and vision are not good and they are often starving for touch." Bartenieff and Lewis (1980) support these observations. They explain, "In the aged and chronically ill especially, the need for tactile stimulation is a hunger which often remains unsatisfied" (p. 292).

Touch and Culture

Montagu (1986) cautions that a wide range of class and cultural differences in attitudes and practices related to tactile behavior exists. The nurses studied were cognizant of these cultural variances and respected their patients' beliefs and preferences.

During a conversation Marie remarked, "I am quite reserved about touch initially. I stand back at first and see what dance they want to dance. I think it's just good nursing to assess it. Not all the same approaches work for every patient, or every nurse."

McCorkle (1974) provides a fitting conclusion emphasizing that patients from varying backgrounds may differ in "both the manner in which they express the need for tactile stimulation and the manner in which they satisfy it...but the need is universal and is everywhere the same" (p. 126). To be truly beneficial it is apparent that tactile communication must be used appropriately, taking cultural mores into consideration.

The Qualities of Touch

The qualities of touch can vary. To be effective in patient care situations, certain elements of touch are most desirable. For example, Green-Hermandez (1991) asserts that caring is transmitted through touching that is neither rushed nor rough in quality.

Bartenieff and Lewis (1980) detail three different qualities of touch: the fleeting light poke, the constrictive two-dimensional grip, and the three-dimensional enveloping hold. They describe the three-dimensional touch as slightly bound in nature and explain that it communicates reassurance and support to the patient. In their opinion, this non-linear, total touch is the most effective in nurse-patient relationships: "A profunctional peck on the cheek is no substitute for a warm embrace, nor is a conventional handshake capable of replacing a caressing hand" (Bartenieff & Lewis, 1980, p. 396).

The nurses interviewed also identified different qualities of their touches. Being mindful of the importance of individualizing their care, the nurses suggested that they were careful to use touches with which their patients felt comfortable. Marie commented,

> The last thing I want to do is scare one of my patients or their families members off because they feel smothered by my physical attention. I try to fit the approach to the patient. Sometimes it's hard to tell with people. If you just talk to them they may seem reserved and not very demonstrative. But if you do take the risk and give them a little test hug, they usually cling on very tightly.

It is difficult to determine some qualities of a touch from a distance. As an observer, the amount of pressure, whether hard or soft, light or heavy; and the temperature, whether warm or cold, of touches could not be determined. However, it was possible to see that the touches used by the exceptionally competent nurses were gentle, not rough, and deliberate and slow rather than rushed. This moment observed provided an example:

> "What can I do to help you sleep better on your first night with us?" the nurse asks a newly admitted patient. The patient, a very frail cachexic man, is withdrawn and reserved. He says nothing.
>
> Not giving up, the nurse makes suggestions. "How about a back-rub or a foot-rub?" She watches the patient for a clue, and when he smiles slightly at the mention of a foot-rub they set a mutually agreeable time for it to occur.
>
> It is one of the most genuine messages of caring I can imagine. The lights are dimmed, the lotion warmed, her voice is soft and often silent. She stands at the foot of his bed so she can look at him as she does her work. Although her night is hectic, she takes her time, moving slowly and lovingly. When she is finished she wraps his feet in warmed towels to prolong the physical and psychological effects after she is gone. The message that he is still an important and worthy person, and that she cares for him, is clearly communicated through her touch.

YOU HAVE THE TOUCH

The touch.

Soft,
gentle,
deliberate,
warm.

The Language of Touch

In the literature, touch has been described as a language. Montagu (1986) suggests it is the language of the senses. Weiss (1979) contends that tactile symbols create the language of touch, producing a channel of communication. Different qualities of touch, used in various combinations are like the phrases of the language. Messages are communicated through this channel (Weiss, 1979). The repetitive nature of touch is like the repetition of words in the language. Repetition in touch emphasizes a message, the same way that repetition in spoken language does.

REPETITIVE TOUCH

I move my hand over yours,
over and over and over.
I don't want to just say,
"I am here for you."
I want to say it very loudly.

The language of touch can communicate affection and warmth (Bartenieff & Lewis, 1980), acceptance and support (Blondis & Jackson, 1982), caring (Watson, 1989), and it can reassure (Montagu, 1986). Like other languages, these exceptional nurses believe the language of touch can be learned. Many spoke of learning it through experience.

Marie noted,

> In the beginning I never touched my patients except to do care. It took me a long time to get comfortable with it, it took me a long time to learn to look past what I was seeing in the bed and see the real person lying there and to feel all right about touching them. Part of it was experience, life experience and nursing experience. Maybe part of it too, is just being more comfortable with yourself and the situation.

Touch Combined with other Mediums of Communication

Touch is seldom used in isolation, as the sole means of communicating with a patient. Regularly, as nurses touch their patients, and their patients touch them, they also engage in other verbal or non-verbal interactions. Most commonly, silence and eye-contact were combined with touch.

Touch and silence.

Watson (1979) explains how touch and silence are often combined: "Although touch may be accompanied by words, it is frequently more meaningful without them. There are times when the best expressions of empathy and concern are in non-verbal touch" (p. 24). When observational data were being collected in the nursing unit, the following situation was recorded. It is an example of how touch and silence were combined to provide support for a family member.

> Her husband of many years has just died from his cancer. She has been out of the room making calls to relatives as the nurse tidies up the patient's room and prepares the body. The wife enters the room and approaching the nurse says, "How can I thank-you?" and begins to cry. The nurse embraces her in a tight enfolding hug. For a few minutes the wife sobs softly into the nurse's shoulder. As she cries, the nurse continues the hug. When the crying stops, the nurse gently releases her and wipes her tears with a tissue that has been waiting in her pocket for just such a crisis. Maintaining contact with the wife by keeping her arm around her shoulder,

> the nurse walks the woman to the elevator. No words are ever spoken. No words are needed.

MAGNIFIED TOUCH

Silence,
a magnifying glass
for touch.

Touch and eye-contact. Blondis and Jackson (1982) declare that the emotional truth is expressed non-verbally. Montagu (1986) suggests that non-verbal messages expressed through eye-contact are very powerful. He adds, "The eyes have a language of their own" (p. 264). When the languages of touch and eye-contact are combined, messages that might otherwise be conveyed very awkwardly in words, are exchanged instantly and emphatically.

As Montagu (1986) explains, "There is something about eye-contact that is almost palpable" (p. 264), and when it is combined with touch there seems to be a synergistic effect resulting in a potent communication medium. Because of the intensity created in the combination, touch and silence were used together discriminately by the nurses being observed, with some caution and with respect. Usually these moments were short. They often occurred in emotionally charged situations where people either did not know what to say, or wanted to say more than words would seem to allow. This is an example of such a moment witnessed:

> She had been a star, an entertainer, a celebrity. Now breast cancer had robbed her of her dignity and her wish to live. On two occasions she had tried without success to hasten her departure from this world. Moments ago the nurse had discovered in her belongings

> enough medication to end her life. At the moment of this disclosure, their eyes met and stayed locked as the nurse walked to her and took her hand. For several seconds they maintained this stance, frozen together in time.

COMPLETE COMMUNICATION

Entranced in your eyes,
the messages come strongly and swiftly.
As you reach out and touch me,
you complete the circuit.
For a moment we are one,
understanding each other completely.

TYPES OF TOUCH

Nurses use various types of touch in their practice (Watson, 1979; Weiss, 1979; Bottorff, 1992). These types are usually determined by the characteristics or purpose of the touch. It is possible to identify several broad classifications of touch from the literature.

One of these, procedural touch (Clement, 1983), also called task-oriented touch (Burnside, 1973), or working touch (Bottorff, 1992) is associated with technical nursing procedures. The purpose of such touch is to maintain health, or provide curative or preventative interventions.

Comforting touch (Weiss, 1986), a second type of touch, has also been called affective touch (Schoenhofer, 1989), non-necessary touch (Barnett, 1972), and empathetic touch (Gadow, 1984). The incentive for comforting touch is easing emotional distress and communicating caring. In her study Bottorff (1992) explains that, "Comforting touch is given for the purpose of providing comfort by calming, soothing, quieting, reassuring, or encouraging" (p. 55).

Connecting touch a third type, is described by Bottorff

(1992) as touch used to, "establish and maintain relationships with patients" (p. 57). She adds that this kind of touch can also be used to attain and maintain the patient's attention or just to reassure the patient.

Bottorff's (1992) orienting touch, a fourth category of touch, she briefly describes as being a sub-category of working touch; however its purpose is to clarify for the patient what is happening, especially during assessments (p. 63).

Finally, social touch is usually affiliated with joking and teasing and is important in enhancing the relationship between nurse and patient (Bottorff, 1992, p. 65).

As mentioned in the introduction to this chapter, Watson (1975) classifies touch more broadly as either instrumental or expressive. Instrumental touch according to Watson (1975) is "deliberate physical contact initiated to facilitate the performance of another act that is the primary aim of the initiator" (p. 104). This type of touch could include Burnside's (1973) task-oriented touch and Bottorff's (1992) procedural touch.

Alternatively, Watson's expressive touch is "relatively spontaneous and affective. It is not required...by the institutional relationship of the interactants" (1979, p. 104). Watson (1979) concludes, "While use of touch by health care givers is primarily instrumental in nature, any given instance of touching may have expressive as well as instrumental significance" (p. 104). There are times when both types of touch occur simultaneously. Comforting touch, connecting touch, orienting touch, and social touch could all be considered at least partly expressive in nature.

It is difficult to label a particular touch as belonging to a single category, although certain touches seemed to fulfill specific purposes. A particular touch encounter however, may achieve a variety of objectives and carry multiple messages. Each touch experience is unique and can be a very private experience between the participants. The stories of the nurses in the study provide insight into the experience from the nurse's perspective, and the observations capture only what could be seen. On occasion, I did ask the nurse to comment on a touch encounter observed in order to provide additional insight.

In the following discussion the examples of touches observed and recorded in discussion and narrative exchange have been grouped according to their apparent primary purpose. Going beyond the types of touches described in the literature, eight different types of touch were identified through analysis of the study data: procedural touch, non-physical touch, talking touch, trigger touch, social touch, diagnostic touch, comforting touch, and the final touch.

Procedural Touch: When a Touch is More Than a Touch

Patients are touched as part of many nursing procedures. However, how a nurse touches a patient during these procedures communicates a great deal about the nurse's feelings for that patient as a person. In this way, a procedural touch may be more than a touch for task-related purposes.

In Bottorff's (1992) study of the uses of touch by oncology nurses, the task-oriented or procedural touch was the one most frequently employed by the nurses she observed. It is the touch that is part of the performance of nursing tasks, such as starting an intravenous line, administering medications, or changing a dressing. If nurses are accomplishing their technical duties, these touches are necessary.

The exceptionally competent nurses did use procedural touches. However, the procedures were done in such a manner that the touches took on certain qualities. These nurses made therapeutic use of the task-oriented touches, taking the opportunity to do their "work" and meet some of the patients' emotional needs simultaneously. For example, when they inspected a sub-cutaneous needle site, they touched the patient to fulfill this procedure, but they did so gently, without rushing to open the gown to access the location. Their actions communicated their concern and respect for the patient.

Often a procedural touch was accompanied by a secondary touch that was not required to complete the task. A squeeze of the hand, a stroke of the arm, or a caress of the face, said, "I care about you." In this way an instrumental and expressive touch were combined.

As they performed interventions, these nurses were able to remain focused on the patients. By providing eye-contact and talking to the patient when it was not critical that they be looking at the site of the intervention, they increased the patient's comfort with the situation and sometimes gathered important data. For example, they were able to assess how a patient was tolerating a procedure as it was being done, and then modified their approach if it was causing the patient physiological or psychological distress. If a procedure was potentially embarrassing or painful for the patient, the nurses were careful to maintain emotional contact with the patient throughout the process.

One specific procedural touch that was used liberally and effectively by most of the nurses observed was the bath. Jane commented on the importance of bathing patients. She said, "Perhaps it is the symbolic nature of water as the source of life, maybe it is the comfort provided by warmth on sore joints, or it could be the stimulation from water pressure on the skin, but whatever the reasons, nurses love to bath their patients."

Other nurses made comments about their use of bathing as an opportunity to communicate with their patients. They also talked about the tactile stimulations of the bath, the whirlpool jets, the bubbles, the hydrous pressure of the water on the skin. Julie laughed and commented,

> We really do wash our patients a lot, probably more than we need to. Let's face it, they don't get really dirty. I think it is a form of therapy. When you combine the stimulation of the water on the skin and the rubbing and scrubbing, it does more than just stimulate their circulation.... It makes them feel much better.

Moria also supported the importance of bathing patients saying, "I give every patient some kind of bath every day. It's a great time to talk to the patients.... There is something about that situation...all the barriers are removed with the clothes, and we really talk." Finally, Lana made this observation, "Giving someone a bath is such an intimate time. I can't think of any better way to get to know my patients."

The dressing change is another nursing procedure that involves touching. This account from my notes on a dressing change observed illustrates the combination of procedural touch with secondary touch.

> The old dressing is gently removed. As she works she watches the patient's eyes and face to see how he is tolerating the procedure. Carefully the wound is cleaned, but before applying the antiseptic, she warns the patient the solution may feel cold. The nurse accurately applies a new dressing. As she spreads the tape to hold the gauze in place, she rubs her hand on the skin around the wound site. She asks the patient if it feels all right, and makes necessary minute adjustments. As she leaves the room, she give his hand a squeeze, and winks at him. They exchange a smile.

In another field note I recorded this observation of a nurse starting an intravenous line.

> She enters the patient's room and explains the doctor has requested that an intravenous be started. In a careful and complete manner she explains the procedure and what the patient can expect. Returning a few

> minutes later with the equipment, she applies the tourniquet over the patient's pajama sleeve so as not to pinch the skin beneath. Gently, she rubs the patient's skin to increase circulation so she can locate the vein. As she rubs, she looks at and talks to the patient. Before she inserts the needle, she warns the patient that there will be pain. She asks the patient how the needle feels, completes the procedure efficiently, and reassures the patient as she leaves by squeezing her shoulder. The nurse places the call-bell within the patient's reach and asks the patient to call if she has any concerns.

These observances demonstrate how the exceptionally competent nurses approached two different nursing procedures. In each situation the dressing is complete and the intravenous is started, but the patient's feelings are respected and simultaneously the patient is comforted and reassured.

Non-Physical Touch

The second type of touch observed was the non-physical touch. In exploring this area, I saw examples that supported Estabrooks (1987) claim that touch can be more than skin to skin contact. Any modality that allows the human presence to be felt is in a way a form of touch. Music, art, literature, intellectual exchange, and non-contact physical closeness could all be viewed as variations of touch that might be called non-physical touch.

The exceptionally competent nurses found ways to touch their patients non-physically. One nurse, Peter, was especially skilled at what I called encircling. He would seldom lay a hand on the patient other than to perform procedural touches, but would often have his arm just behind the patient's back or around the patient's shoulders. Although no physical contact was made, I sensed that the feeling of support was present. The following is an excerpt from a letter I wrote to Peter summarizing some of my observations of our time together.

> Finally, I was most affected by your gentleness of manner and by the tenderness of your touch. Your hands are so amazing. Even from a distance I could sense an aura of warmth and healing flowing from them. You have no need to physically touch your patients because you have the ability to encircle them with compassion and caring without direct contact. What power! Your patients are very fortunate to have you as their nurse.

My corresponding field note said, "He doesn't touch as much as he is physically close...and looks directly at the patients, staying at eye-contact level. He encircles them with his warmth without direct contact."

Montagu (1986) suggests eye-contact is a variation of non-physical touch. He calls eye-contact "touching at a distance" (p. 124). In conversation Julie echoed this view when she said, "To me touching is critical. It communicates empathy, caring, affection, concern.... All of this is transferred through touches with your hands and touches with your eyes." Levine (1987) describes eye-contact touching as "looking through soft eyes." Soft eyes, he claims, allow you to see with the heart. I believe this is often the way that the nurses I observed looked at their patients.

SOFT EYES

Your eyes throw light at me.

Some of it I store - my source of hope,
some of it I consume - my source of energy,
some of it I reflect - our source of unity.

Talking Touch

What are the messages embedded in touch? At certain times, when it seemed inappropriate or too difficult to use words, or the right words to communicate a feeling could not be found, touch was used. This type of touch I have labelled talking touch. Bartenieff and Lewis (1980) describe touch as "the authentic voice of feeling" (p. 287). They conclude, "like music, [touch] often utters the things that cannot be spoken. Nothing need be said, for everything is understood" (p. 287).

In some ways talking touches share similarities with Bottorff's (1992) category of comforting touch. As described earlier, comforting touches by Bottorff's definition are given for the purpose of calming, soothing, quieting, reassuring, or encouraging patients. Although talking touches do in part meet these goals, they also are used to communicate a variety of additional messages. As the following examples illustrate, talking touches can be used to give the patients specific messages and directions and are a vehicle for the nurses to share their feelings with the patients and family members.

The following field note describes the use of talking touch by one nurse.

> As she cared for the patient and the grieving family, she never said, "I really care," but she said it many times non-verbally by her gentle touching of the patient. Her concern with keeping him comfortable in his final hours: hair-combed, mouth and lips moist, her willingness to be the someone close by when the family faced the final moment, all told the family what they needed to hear.

Montagu (1986) said, "Touch communicates the feeling of love. Stroke, caress, cradle, comfort...imply involvement, concern, responsibility, tenderness, and awareness of the needs, sensibilities, and vulnerabilities of the other" (p. 216).

A multitude of feelings were communicated through talking touches to the patient and family members in this situation.

> The patient is very ill, in fact, terminal. As the wife and daughter pace anxiously in the hallway outside his room, the nurse approaches them and touches each on the arm as if to say, "I see how difficult this is for you." She leads them into the room, and pulls a chair close to each side of the bed, encouraging them to sit with him and hold his hands. From time to time, the nurse gently places her hand on his pulse or touches his extremities, monitoring him closely but unobtrusively. The priest, summoned by the nurse, prays for the patient; as he does the wife looks questioningly at the nurse. She responds to the non-verbal question of "How much longer?" by placing her arm around the wife's shoulders. The patient dies peacefully. The nurse beckons the family to follow her down the hall to a quiet room where they can sit for a while. She stays with them, sitting close by and touching them often as they cry.

In talking with the nurse Marie about this moment she said, "Sometimes those little touches just let the patient or family member know that I am there for them. What I am meaning to say is I'm available to you in this time of need."

Some nurses in this study indicated they use touch to communicate to patients that they are important to them. Jane commented, "If I think about why I do what I do...I always use a person's name, stand close, look at them, and touch them lightly on the hand or forearm as I speak. To me, this tells them that I am not too busy for them and that I do care."

Touch was used to talk to the patients when the news was too sad or difficult to be put into words. Julie remarked, "When the patient has just heard some really terrible report from the doctor, there is absolutely nothing to say that will match the intensity of the emotion." Lana agreed saying, "Bad news can only be met with touch. Putting it into words and talking about it right away make it too real. Nobody can bear it, not the patient or me. At times like that I just hold them."

NO MATCH

Stumbling over my tongue,
words are a feeble match for the
relentless pounding of grief.

Trigger Touch

> Her husband was only 30, dying a slow painful death from stomach cancer. She was so strong, sitting by his bed all day, sleeping by his side at night, eating all of her meals next to him. The days stretched into weeks and still she stoically sat, asking the nurses and doctors for very little as she met most of her husband's physical and emotional needs.
>
> I wondered about her pain and I worried about her.... I sought an opportunity to get inside, and finally one day it came.
>
> His supper tray was late, and she was pacing the halls

> awaiting its arrival. Her forehead was riveted with strain and anger. I approached her slowly, silently, and when we were close in physical distance I touched her elbow and said, "It looks to me like you are sitting on the edge of tears. Can you share them?" In a great guttural cry the weeks of frustration and anguish poured freely.

This story provides an example of a trigger touch, a touch that elicits the release of pent-up emotion in the person touched. One nurse, Moria, observed, "Anger, sadness, or despair may come rushing out as a hand laid on a shoulder or a hug says, `I'm here for you, I care about you, you can trust me with yourself.'" Watson (1989) supports this observation saying touch may release a person from self-absorption or suffering.

In conversation Mindy told me that she watches for critical talking moments, times when a patient or family member who has been under stress "looks ready to let it go." She said, "Most times it's a little touch combined with a few words that give them permission not to hold it in any longer."

I observed this nurse utilize the approach she described. The wife of a man whose condition had been deteriorating daily was sitting outside her husband's room reading. Approaching the woman, the nurse knelt before her and taking her hand said, "You must be tired?" With that small gesture, the words, worries, and tears that had been stored up for many days came out without hesitation.

In analyzing her approach she said, "It is a risk every time you do something like this. You might get rejected, verbally or non-verbally, but usually they really want to talk, they just need to be given the chance. You also have to be prepared to deal with whatever you uncover."

JUST ONE TOUCH

Just one spark,
can start the forest burning.
One rock removed,
begins the avalanche.
A single touch
can prompt a stampede of emotion,
the strength of which
could make any iron-man shiver and shake
and beg for mercy.

But don't be afraid.
Unlike the fire and the avalanche
that bring destruction,
once the stampede of emotion has past,
genuine calm can prevail.

Social Touch

Bottorff (1992) and Montagu (1986) identify a form of touch they called social touch. By their definition social touch is human physical contact that fosters social bonds, attachment, and permits individuals to maintain their emotional integrity. Montagu (1986) explains that, "cheek patting, hair patting, and clucking under the chin, in the Western world, are forms of behavior indicating affection and social recognition" (p. 270).

In my observations many of the playful touches such as pretend punches, taps on the nose or cheek, or toes pulled gently were all touches of a social nature. Such physical contacts were made appropriately either during moments that were less emotionally intense or to diffuse a difficult situation.

Some social touches seemed to convey a sense of friendliness and playfulness between the two people involved. For example, I observed one nurse trying to get a response from a patient who, although he was physically quite well, had been lying in bed, staring at the ceiling and refusing to interact with anyone since his admission two days earlier. In my field notes I wrote,

> Every time we enter the room she places her face very close to his, takes his large hand firmly in hers, and talks to him in a playful, yet respectful voice. On one occasion she touches his hand to her nose in a sprightly affectionate gesture...and there it is, a tiny upward crease forming at the edge of his mouth. She has a reaction.

Another nurse Jane, habitually pinched her patient's big toe as she entered or left the room. When I asked her about it she said, "I just do it to sort of lighten things up.... It's like a bit of fun in a rather serious place. I hope it relaxes them and lets them know it's still O.K. to play."

At other times nurses used modifications of more conventional social touch such as the handshake to signify official acquaintance. Although a formal shaking of the hands was seldom observed one nurse, Maureen, described how she introduces herself to patients.

> When I introduce myself I go up and tell them my name and touch their hand lightly. It's like a handshake, only more. It formalizes our meeting for the first time, but it allows me to find out about them. Do they like to be touched for example, or are they very apprehensive about being here?

In this way the social touch serves more purposes for these nurses than the traditional recognition of the other. It is in some ways also a first assessment of the patient's needs, and a communication to the patient that the nurse is willing to engage in mutual touching.

Diagnostic Touch

Nurses may "identify through touch...body heat, discern skin textures, and recognize changes, favorable or unfavorable" in the patient's condition (Montagu, 1986, p. 133). Touch that is primarily for such a purpose I have called diagnostic touch.

The nurses observed used their hands to assess the patient. For them touch was an important means of discriminating diagnosis. Several nurses talked about this important function of touch saying,

> Feeling my patient's skin tells me a lot.... I touch them to see if they're cold, sweating, dry, or feverish.
>
> I read my patient's status with my hands.
>
> I have tested myself, I can tell a patient's temperature with almost perfect accuracy without using a thermometer.
>
> I couldn't start an I.V. if I couldn't see the veins with my fingers.

How did they develop such an acute and accurate sense of touch? The consensus among those nurses with whom I discussed this was that they learned through experience. Lana said, "When I first started I didn't know what hot was. Now that I have felt thousands of foreheads I compare what I feel to what I know normal feels like." As the comments cited imply, diagnosis of a patient's physical status often comes to the exceptionally competent nurses through their sense of touch.

Comforting Touch

Touching was a means used by these nurses to comfort their patients. Morse (1983) claims that the two major components of comfort are talking and touching. She explains, "Comfort measures vary according to situation, context, and meaning to each subject" (p. 16). Depending on these factors, the nurse can choose to talk only, talk with a little touching, or touch with little talking. In Morse's (1983) opinion, all three approaches could comfort a patient.

Benner (1984) recommends the use of touch in providing comfort stating, "Nurses frequently use touch to provide comfort and reach out to a withdrawn, depressed patient. Often, this human warm contact is the only avenue of comfort and communication available" (p. 63). Montagu (1986) agrees and explains that, "Taking almost anyone's hand under conditions of stress is likely to exert a soothing effect, and by reducing anxiety it gives both the receiver and the giver a feeling of greater security" (p. 284).

The nurses interviewed were in agreement with these authors. Julie stated, "Our families in this society are so disseminated and alienated, the only way you get them comfort is through the touch of human kindness." Jane commented, "I think that a lot is communicated through touch. You can show concern...and break down a lot of barriers with touch. It affirms the patient as more than an object. It gives them the ultimate gift, comfort."

McCorkle (1974) asserts that the use of touch and physical closeness may be important ways to communicate to acutely ill persons that they are important as human-beings, yet critically ill patients are seldom touched by their care-givers in non-technical ways. She saw the barriers created by the mechanical means used to support life as inhibiting the use of human contact in providing comfort. A situation observed provides an example of how the nurse worked around such barriers to bring the patient comfort.

> The patient is dwarfed by the obtrusiveness of the machines. On both sides of the bed infusion pumps beep out their progress. Multiple bags of red-labelled solutions drip along keeping time with the mechanical tones. Chest tube suction devices bubble and honk intrusively. Both side-rails are in their upright position; the aim, to keep the patient in; the result, the world is kept out. The nurse walks up to the unresponsive patient and for a minute watches his shallow breathing. Then she reaches past the cumbersome array of machines and rests her hand on his still shoulder. As she leaves, she gently brushes a few strands of hair back off his forehead.

One day on the unit Julie talked to me about how she uses touch to provide psychological comfort to the newly admitted patient. She said, "When a patient first comes through those doors, no matter how prepared they think they are, they really aren't. I try to establish some connection with them right away. Often it's just as simple as a little touch." Later she told this story.

> We had an HIV fellow with Karposi's sarcoma, a new admission. I was going to help him with his meal. I didn't have any gloves on. This was his first supper with us and he was totally coherent and a little anxious. I introduced myself and was giving him some help with his house coat and he said, "You don't have any gloves on, aren't you scared?" I said, "Well, are you going to bite me?" He laughed and said, "No, but in the other hospital that I just came from everyone wore gloves and gowns every time they came into my room." I just explained to him that when I changed his dressings I would wear gloves but that there was no medical reason to now, and I just kept helping him with his clothes.

After telling me this story Julie made additional comments, saying,

> I think I really made him feel comfortable, not that I even touched him that much at that moment, but I showed him I was willing to touch him. I don't think he had been touched by human hands, that weren't covered in gloves, for a long time. Touching him removed huge potential barriers between us and made him feel a lot less anxious.

In making this patient comfortable and comforted, the nurse felt more comfortable herself. As Peterson (1985) sees it, touching is a symbol of caring, a means to share feelings. It has a dual nature; we use it to comfort each other.

In another experience on the unit I watched a nurse bring physical comfort and restore control to a patient who was struggling to breathe. This is the field note that described the situation.

> Even before we entered the room, I could hear the desperate gasps for air. As I laid my eyes on him I could see his struggle. Starved for oxygen, physiologically by his disease, and psychologically by his mind, he fought for every breath. I watched as the nurse walked to his side and took his hand. In a very soft and reassuring voice she said to him over and over, "Take it easy, relax, take it slower." Her

> repetitive words were matched by repetitive stokes of his forearm. She was so calm herself, and as his eyes fixed on hers, together they slowed his breathing down until the desperation left.

THE COMFORT OF A TOUCH

Soothe, support, strengthen.
You can do it all with
just the perfect touch.

The Final Touch

> Sophia was dying. Life had become heavier than death. Her nurse was aware of her reality and visited her room often that day. Most times there was no medical reason for her visits, she would just hold Sophia's hand, stroke her forehead, sometimes she would pull up a chair and sit for a few minutes and read some of the get-well cards that Sophia could no longer see for herself. This seemed to be exactly what Sophia needed. Someone who was willing to be near, to touch her gently.

Many of the nurses in this study expressed the belief that the sense of touch is one of the last, perhaps the last sense to leave the dying person. They agreed with Watson (1989) who claims, "Patients who have no apparent verbal capacity can usually feel a gentle touch and understand its message of caring interest" (p. 23). Because of this belief, the exceptional nurses used touch, sometimes exclusively, in communicating with patients during their last days. Maureen phrased it like this:

> I believe that when someone is dying they feel touch until the very end. I tell the family that and I encourage them to hold hands and stroke the patient's forehead. I do it too, just to let them know I am still with them.

Another nurse Julie said,

> I use touch a lot when a patient is dying or has just died because I believe it is extremely important. I have found that the families watch you.... When I go into a room just after a person has died I always talk to the patient and say good-bye and I always touch them.

> It seems to make it O.K. for the rest of the family to do that. I have had a lot of positive feedback from families about it.

She then went on to tell me this story:

> A young man was dying, in a coma and totally non-responsive. I called his Mom and Dad (they lived out-of-town) and they arrived just in time for their son's dying day. I encouraged them to help me with his care, to touch him and talk to him. I got them chairs and coffee, and checked in on them often. When I cared for him myself, I reminded him of the presence of his family and I tried to set an example for them to follow.
>
> Near the end they were doing really well and I witnessed something I will never forget. His Mom was washing his face, probably just like she had when he was a little boy. For just one short moment he opened his eyes. He hadn't done that for many days. I know he saw her and she saw him. It was a wonderful moment, a last good-bye.

When I asked about her approach to caring for patients near death, a third nurse Lana simply said, "I never leave a dying patient without a hand to hold." Several nurse researchers agree with this belief that touch is important in the last hours of life. Blondis and Jackson (1982) contend that, "A great many needs of terminal patients will be satisfied non-verbally through empathetic nursing care. The psychological impact of non-verbal communication, especially of touch, on the dying patient cannot be underrated" (p. 161). Watson (1989) agreeing with this point reports that, "Our first contact with life is through touch as an infant...our first comfort in life comes from touch and usually our last. Through touch we may communicate with comatose, dying patients when words have no way of breaking through" (p. 22).

A story written by Marie illustrates that the use of touch in the final moments is effective even if the nurse is unfamiliar with the patient and family.

> It was a busy shift. I had been away on holidays for a month and this was my first shift back. The only patients I knew on the ward were the six I was assigned to. It was about 2100 hours and I needed a dressing tray so I was walking quickly towards the clean utility room to get one. The hallways were darkened and as I walked by a patient's room I was grabbed by the arm by a visitor beckoning me, "Nurse, please come," he said. I entered the room of a patient who was taking his last breaths. He ceased breathing and I looked up at the faces surrounding me. "Is he gone?" asked a younger man, presumably his son. "Yes," was all I could think of to say.
>
> I felt so inadequate at that moment, I didn't know his name, the family, or the previous circumstances. I stumbled, "I'm so sorry," and sat down with them holding onto a hand and a shoulder. I knew I was needed by my own patients, but this moment demanded every inch of me now. I noticed how peacefully he died so I shared that with the family, and they shared a few memories with me. For those few initial moments we mostly just sat and held hands. It was like they needed a nurse present for this rite of passage. Soon, the patient's nurse arrived and I scurried down the hall realizing I had a dressing to do.

When I talked to Marie about this situation she offered further insights. She said,

> This man was taking his last breaths.... All I could do was bring his family closer and put their hands on him while I supported them. I realized afterwards how quickly we move in and out of people's lives. I did not know their names, but that short interlude was strengthening to me. I was needed and I also received. I think it was touching that allowed us to make an intense connection in a very short time.

THE UNKNOWN PATIENT

You call for a nurse,
and the nurse in me instinctively responds.

You are alone and afraid
in this moment of need.

I don't know you,

yet you are so familiar to me.
I sense your anguish, your uncertainty.

Hand in hand we unite our spirits
and send your loved one on his journey.

CHAPTER SUMMARY

To summarize this discussion several remarks seem appropriate. First, the examples and stories suggest that touch is reciprocal. In some ways both the patients and the nurses appeared to be affected by touch events. Tough (1989) concludes, "It is clear that human contact is synonymous with feeling cared for and about as human beings" (p. 120). Touch provides an extension of the human presence. It is an expression of the nurse's participation in the patient's experience. As you touch so are you touched. As Montagu (1986) states, "The two-way communication we transmit through touch constitutes the most powerful means of establishing human relationships, the foundation of experience" (p. xv).

Second, despite an interest in the use of touch and a general agreement that touch is important in nursing practice, research on the significance and dimensions of touch is in its early stages. This study goes beyond the descriptions of touch that are provided in the literature.

Third, there seems to be a consensus among nurse researchers and scholars that touch is important and appropriate in health care. It is suggested that touch can serve a variety of purposes including decreasing patient anxiety and isolation while helping the patient to feel safe, valued, reassured, and comforted.

Fourth, touch can be, and often is combined with other verbal and non-verbal mediums. For example, this study suggests that silence and eye-contact can both magnify the positive effects of touch.

Finally, eight types of touches are identified and described in this dissertation. These categorizations go beyond earlier discussions of types of touch provided by other researchers. New categories of non-physical touch, trigger touch, talking touch, diagnostic touch, and the final touch were described in this chapter.

REFLECTIONS ON MUTUAL TOUCH

The following reflection on mutual touch contains two sub-sections. First, I look at the similarities between touch and silence. Second, I compare the categories of touch identified by Bottorff (1992) with the categories identified during this study.

Similarities of Touch and Silence

As I observed the study nurses I began to notice that these two actions, touch and silence, have many similarities. Although they need not always be companions, touch seems to be a natural complement to silence.

Like the dialogue of silence, mutual touch is a non-verbal form of inter-human communication. Touch shares a further similarity to silence in that both affect the sender and the receiver, the toucher and the touched.

Touch, like silence, was effectively used by the nurses studied in both emotionally demanding circumstances and during everyday patient encounters. Both touch and silence were used to communicate and receive messages, feelings, and emotions that would be difficult to share in any other way. Touch and silence both facilitate the sharing of emotions.

Comparing further, messages sent through silence and touch involve the similarity of instantaneousness. That is, messages embedded in silence and touch messages are received as they are sent. There is usually no delay. Both participants can send and receive messages at the same time, making these two modes of communication efficient.

Unspoken messages are embedded in touch and silent exchanges. Messages that may give the patient comfort and humanize the situation. Although silence and touch are often only a part of a nursing intervention, they are components that seem important in exceptional nursing practice.

Comparing Bottorff's Categories of Touch to Those Identified in This Study

Bottorff's (1992) study of the use of touch by cancer nurses compares most closely with this study. In both projects cancer nurses were observed while they cared for patients and their behaviors were categorized into types of touch as defined largely by purpose.

As described earlier in this chapter, Bottorff (1992) identified five types of touch: procedural, connecting, comforting, orienting, and social. The findings of this study describe three categories that overlap with Bottorff's classifications, specifically, procedural, comforting, and social types of touch. However, five additional types of touch are identified and described in this dissertation: non-physical, diagnostic, trigger, talking, and final touch.

Comparing the findings of the two studies more closely it is possible that some of the new categories could be sub-categories of other classifications, or perhaps, alternative labels for Bottorff's categories of orienting and connecting touch that were not identified during this study. However, I suggest that this is not the case and that the five new categories identified were previously unidentified.

This leads me to wonder about Bottorff's categories of connecting and orienting touch that were not revealed in this study. It is possible that additional time at the study site would have produced data leading to the development of similar categories. Alternatively, perhaps these categories could be sub-categories of Bottorff's other categories. For example, social and comforting touches could also be connecting touches. In the same way, social and comforting touches could also serve an orienting purpose.

This discussion of possibilities is illuminating in two major ways. First, it reminds us that it is difficult to distinguish between types of touch as an observer. Without discussion with the nurse and the patient after each touch encounter, the researcher is speculating on the purpose and effect of the touch. Second, the categorization of types of touch is arbitrary at best. Perhaps it is even unnecessary to make such artificial boundaries. In all likelihood most touches probably serve more than one purpose.

Although these questions and concerns can not be addressed fully within the scope of this study, one general conclusion can be drawn. Touch is important in exceptionally competent nursing practice and a touch encounter, whatever its primary purpose, likely has an effect on both the nurse and the patient.

THE IMPRINT

Your touch.
A gentle brush across my cheek.
How can something so faint,
so soft,
so subtle,
leave such an indelible imprint
on our souls?

Chapter 7

SHARING THE LIGHTER SIDE OF LIFE

CHAPTER INTRODUCTION

> A merry heart doeth good like a medicine;
> but a broken spirit drieth the bones.
> (Proverbs 17:22)

This chapter focuses on the third theme in the trilogy, sharing the lighter side of life. A review of the data collected reveals a light-hearted attitude is common among the exceptionally competent nurses. Despite tragic circumstances in their work lives, these nurses deliberately choose most times to see the positive and humorous side of situations. Importantly, they are able to share this orientation to life effectively and appropriately with their colleagues and patients.

The literature refers to this approach in a narrow sense, labelling it the deliberate therapeutic use of humor. Intentional attempts to introduce humor into patient care using comic videos, cartoons, jokes, and clowns are recommended by several writers (Pasquali, 1990; Parfitt, 1990; Gaberson, 1991; Erdman, 1991). Although excerpts from the literature are included in this chapter to augment the discussion, this presentation goes well beyond the staged use of humor in nursing care. As Thomas (1983) says, using humor is more than the presence of a nurse who is a stand-up comedian, an entertainer.

The seventh chapter is divided into five major sections. First, a brief review of the state of nursing research on humor is offered. Second, a definition of this light-hearted attitude is provided. Third, four functions of humor, specifically the communication, social, psychological, and therapeutic purposes are described and illustrated with examples from the data. Fourth, different forms of humor: surprise, word play, black, situational, and divergent humor are discussed. Finally, a comment regarding the development of a light-hearted attitude is provided.

As part of the data analysis, poems are incorporated into the text of the chapter. The nurses' words and the field notes illustrate the theme. In this chapter the narratives are especially detailed because, as Benner and Wrubel (1989) caution, "Humor is not easily understood out of context.... It is specific to the situation and easily misunderstood" (p. 19).

THE STATE OF NURSING RESEARCH ON HUMOR

Research on the use of humor as a nursing intervention has evolved, although much work remains to be done in order to achieve a full understanding of the place of humor in nursing care. Both the effects of deliberate humor and nursing attitudes toward humor have been studied by nurses, but the research has been largely quantitative.

Norman Cousins (1983) was one of the first to write about the use of humor to improve health. Nurse researchers subsequently became interested in the value of humor in patient care. The use of humor to decrease preoperative anxiety (Parfitt, 1990) and to enhance effectiveness of preoperative teaching (Gaberson, 1991) have been studied and positive correlations found. Moses and Friedman (1986) tested deliberate use of humor in decreasing anxiety in student nurse evaluation sessions and again it was found to be effective. Hinds, Martin, and Vogel (1984) used grounded theory methodology to study the use of humor in influencing hopefulness among adolescent cancer patients and found a positive influence present. The attitudes of nurses toward the conscious use of humor has been researched by Erdman (1991). She concluded that many nurses view using humor as unprofessional.

In summary, through research, humor has come to be recognized as a technique that causes relaxation in patients and others; as a coping strategy; and as a teaching strategy. However, no description of the part that humor plays in the light-hearted attitude described and displayed by the nurses in this study was found. Similarly, the effects on the patients of sharing this attitude remains largely undisclosed.

DEFINING THE LIGHT-HEARTED ATTITUDE

Defining an attitude is difficult. In an attempt to describe what is meant by a light-hearted attitude four topics are addressed in this section. First, the part that humor and laughter play in this orientation is described. Second, to provide a picture of what such an attitude may look like, various qualities that may be components of this attitude are identified and illustrated. It is proposed in the third sub-section that the element of choice plays a part in whether a person has a light-hearted approach. Finally, the role that this orientation to life plays when circumstances are tragic is outlined.

Humor and Laughter: A Component of the Attitude

Thomas (1983) contends that defining humor is like "tacking jelly to the wall." Humor is an elusive concept. Originally, the term meant a liquid that flowed within the body controlling one's health and disposition. Physicians attempted to keep people in "good humor." Humor continues to be considered in part as an internal condition, as in one's sense of humor.

Lefcourt and Martin (1986) define humor as, a "complex...cognitive and emotional process" (p. 57). Hunt (1993) establishes that humor can be "many things to many people," that it must be interpreted, and that it is "whatever people think is funny" (p. 35).

Baughman (1974) identifies humor as "our sixth sense...as important as any of the other five" (p. 52). He writes,

> Much more should be said and written about humor for so many think it means no more than the ability to tell a funny story or to respond to one. Actually, a sense of humor refers to a complete philosophy of life. It includes the ability to take it as well as to hand it out. It includes poise, the capacity to bend without breaking, taking life's responsibilities seriously but oneself not too seriously.... Other less obvious components of humor are these: the ability to relax, to

> escape from tension, to get pleasure out of the joys of others, to live unselfishly, laughing with people. (p. 52)

This broad definition of humor is congruent with the attitude displayed by the nurses in the study. However, laughter, though often the result of humor, is viewed in the literature as different from humor. Thomas (1983) defines laughter as a bodily response to things that are both humorous and not so. Lefcourt and Martin (1986) suggest it is "a reflex-like physiologic-behavioral response" (p. 58).

Many of the exceptional nurses commented that laughter does not necessarily follow a humorous incident. As Julie explained, "Sometimes when a situation is really awful all you can do is laugh. We had a family member who giggled as a reaction to tense situations. He just couldn't deal with what was happening. Especially when it wasn't funny he would laugh."

Humor and laughter are a part of sharing the lighter side of life, but this attitude goes further. It is an all encompassing attitude, an ability to see the lighter side of situations and encounters as they occur. It is a daily, moment by moment alertness to the possibility of seeing the funny, the humorous, the laughable even in the most unhappy and desperate moments. This attitude served as a lens through which the nurses studied viewed their worlds, and through which they helped others to see their own worlds differently.

What does it mean to see the lighter side of life? It is a state of mind in which the humorous, the bizarre, and the less traumatic are seen in the events of life and responded to in a light-hearted way. Gelazis (1985) reports a sensitivity to life's lighter side involves a spontaneity, light-heartedness and an ability to play, all of which are needed for humor to occur (p. 161). As Leacock (1938) said, it is "seeing the fun of the thing."

Qualities of a Light-hearted Attitude

How does one recognize a light-hearted attitude in another person? The nurses I observed and talked to displayed this orientation to life in a variety of ways. Part of it was non-verbal. Their physical appearance, the way they dressed, moved, and used gestures signalled that they were positive, energetic people, open to sharing their vitality. These descriptions of some of the nurses from my field notes illustrate this attitude:

> She is bubbly, full of energy and lustrous smiles. Today she is wearing a bright peach uniform, and a name tag that is far from ordinary.
>
> This morning she greeted me with a big genuine smile. The multi-colored smock that she wore over her whiter-than-white uniform made me notice her.
>
> Her arms move in time with her words, her steps are never hesitant. She is open, uses direct eye-contact, laughs easily, and proclaims, "I can't be phoney."
>
> His approach is playful and full of fun...yet very respectful. Looking into his eyes you see life.
>
> She smiles a lot. I am at once attracted by her energy and vitality. She is someone I want to be around. It's hard to put into words, but she is somewhat like a magnet, attracting me, pulling me to her.

A second part of their positive view of life was shared through the verbal components of their nursing care. The delivery of their comments, including the timing of presentation, was important in communicating this attitude. In one field note I wrote, "The quality of her voice, the cadence and rhythm of her speech, all communicate this sense of zest for life."

One nurse I observed, Peter, was especially effective at incorporating playful comments into his patient care activities. As he was helping a patient put on his pants without success, he would say, "Maybe we should try to get one leg in each hole." While handing out menus on which the patients would mark their meal choices, he would smile and say, "Here's your homework for today." These little side-comments and the buoyant way they were delivered always made the patients smile.

Choosing to see Humor in Difficult Situations

Looking on the bright side of life is a conscious decision that in time becomes a habit (Maltz, 1970). One of the nurses, Julie, shared this belief. She felt that every person has a choice about how they view the events of life. One story she wrote ended this way, "Everyday is a mixture of good and bad. No day is 100% good or bad. But you will have good or bad days depending of your focus." When I asked her about the origin of this attitude she told me about a statue that she had seen in New York city. It was a cage, and inside was a pregnant woman with several children clinging to her skirts. The caption read, "We build our own cages." Julie went on to elaborate saying,

> We are empowered to make choices and unfortunately we get into situations where our horizons are the edges of the ruts that we dig for ourselves. When that happens, we can't see to either side or the light at the end of the tunnel. It takes the fun out of things. If we just realize we have alternatives as to how we see life, we can breathe.

Another nurse, Jane, wrote, "One's perspective makes all the difference in whether or not any experience is transcending, transforming, depressing, or devastating to the people involved."

Marie said, "When I was thinking of stories to write for you, I found that many of the most significant made me chuckle." This humor affected the way the nurses perceived and performed their work. The following stories are examples of how the nurses chose to see the humor in unusual patient encounters:

> There was this male patient, he was in isolation so no one could go into his room unless it was really necessary. Often, I would just stop by the door of his room to say "Hi" and see how he was doing.
>
> On one visit he mentioned he was cold. I said I would try to get help, but it was unlikely a repair man could go in to fix his radiator. He smiled and said, "Not a problem, I happen to be a repair man myself." I jokingly said, "Do what you can," and left.
>
> The next time I walked by his room, I peaked in and he had the whole radiator panel off. Parts of the radiator were on the floor. I said, "What are you doing?" He answered, "Not a problem, I've got it under control." What could I do? He was so happy, passing the time, his hands were full of grease and he was smiling. So I just said, "That's great, but we won't be paying you." By the time he was discharged it was all cleaned up and until now it has been our secret.

Another nurse, Marie, told this story:

> Mrs. Ling really helped me appreciate cultural differences and to see how some cultures clash with the hospital culture in a funny way. I don't know why but Mrs. Ling really liked me. I didn't even speak Mandarin Chinese or anything. To show her appreciation to me, one day when I went into her room she pulled out these long, slimy, red ginseng roots. She said, "Is good, you eat it." I took it and smiled and slipped it into my cheek as I stepped out of the room. I didn't eat it. I just kept hoping that she was right, that it was ginseng. When I think of it, even at the time I saw the humor in it. What a funny sight we must have been, this tiny elderly woman giving me this great "gift" and me trying to stuff this "worm" into my cheek without gagging, all the while maintaining a look of sincere gratitude. I just had to do it because I thought it was probably really important to her. She probably loves the stuff and she had it saved for me. It was a symbol of her gratitude. It still makes me laugh when I think of it.

This is another difficult situation Marie described to me as "humorous."

> I was calling this "gentleman" patient for seven consecutive days at home. He was on a research protocol and as part of the procedure, I had to phone him and find out how he was doing with his medication and what his pain level was. He was just a really coarse sort of guy, you know, he had frayed edges. When I'd call he'd say, "How the hell do you think I am? I'm not taking this damn stuff anymore." When I'd ask about his pain level it would always be ten out of ten.
>
> One night when I had to call him, I was not at the hospital, I was at the exhibition. The only phone I could find was in the Silver Slipper Saloon. Phoning him was the last thing I wanted to do. When I called, he characteristically said, "Where the hell are you, at a bar or something?" I said, "You are right, I'm at a saloon."
>
> At the time he was shocked, but we laughed about it together even a day later. I heard that he died, but I was happy that I had this wonderful memory of him. It wasn't tender. We were never close and we certainly never touched each other, but maybe I touched him with my "humor," and he did touch me with his.

Finally, this story is of a demanding moment the nurse described as "the kind that really challenges your funny bone."

> Sarah was a Native woman from the reserve. She hadn't been to the city many times and now she had to be hospitalized and was totally overwhelmed by the whole thing. She was my patient and she had to go for a diagnostic test. I had to get her ready to go. She didn't know English, and I didn't know Cree, but I did my best to demonstrate what would be happening to her. She finally understood that she had to take her clothes off and go to the procedure wearing just a hospital gown. I just smiled every time I went to her room. She was just a joy to me, no teeth, beaded moccasins, skin of leather.... She had really lived the tee-pee life.
>
> The vision I have is of me trying to coax this woman onto a stretcher to go for the procedure. Here I am, a white woman, coming into her room, demanding her clothes, trying to give her an injection in her buttocks.... It was just against her whole tradition, her whole culture; it was just too much for her.
>
> In a swift decisive move Sarah jumped off the stretcher and ran in her moccasin slippers down the hall. Most of the staff were running after her. I was trying to stay calm, saying to myself, "you can handle this," but another part of me was just so tickled by her spunk. I was cheering, "Way to go Sarah!"

In these and similar situations, the nurses' inclination might have been to react in a negative way, becoming upset or angry. However, the nurses in the stories were open to seeing the humor in the incidents. At the moment the event occurred, and later as they recalled the situations, they chose to see the lighter side.

MAINTAINING THE ATTITUDE

When things are going well,
it's easy to keep the rhythm in your step,
the enthusiasm on your face,
and the shine in your eyes.

But when life gets challenging,
ordinary people lose it.

You don't.

Appropriateness of Humor in a Tragic Environment

The sage Epictetus says, "Men are disturbed not by the things that happen, but by their opinion of the things that happen." Maltz (1970) agreed saying, "In the most tragic conditions and adverse environments, being sad and heavy yourself adds to the unhappiness" (p. 90).

If a light-hearted attitude is a blueprint for survival, it is not surprising that humor and laughter were present on the cancer unit. Blondis and Jackson (1982) agree and comment that nurses may need to joke and laugh to cope with the seriousness of such an environment. Feelings that are too painful to deal with can be put on hold or eased by humor. Benner and Wrubel (1989) share this view and add, "Humor is used to establish rapport and alter situations of grave seriousness and despair" (p. 19).

In the same vein, McDougall (1963) writes, "Humor was devised so that we would not be overwhelmed by the misfortunes of life. We are inclined to sympathize too much, and we would be devastated if we did not have an antidote. Laughter is that antidote" (p. 135).

If we accept Baughman's (1974) views on humor it makes it understandable why humor is appropriate and important in an oncology setting. Baughman proclaims, "Humor is that soothing and compensating piece of mind which prevents us from being overcome by life's adversities. It can dissipate the fog and make life more enjoyable and far less threatening" (p. 52). Agreeing with this view, Blondis and Jackson (1982) write,

> Humor can be realistic, reflective, or honest, and some of our best humor comes out of tension, turmoil, and anguish. It can play an important role in helping our patients, our colleagues, and ourselves.... Humor is a means of addressing all that is imperfect in the human condition, it provides a feeling of relief. (p. 188)

After one of my first field days I wrote,

> I am surprised by the amount of teasing, joking, and laughter here, not just among the nurses, but with the patients too. I just didn't expect it in an environment that has so much potential to be dark and depressing. Somehow humor and laughter decrease the gloom and replace it with a sense of merriment.

Mindy told me, "There is always laughter on this unit. It's important for all of us. Some patients say hearing the laughter makes it human here."

As I continued to collect data my first impression was confirmed. Three nurses explained why it is important to their success to see and share the lighter side of life.

> I enjoy sharing laughter and do it a lot. I'll see a situation and then inject the absurd into it, just to get a laugh. It's especially important here because people can be stressed and depressed. Laughter sets people at ease. It gives them permission to be spontaneous, to be themselves. It tells suffering people that it's O.K. to smile.

> It's normal and natural to laugh.... It's abnormal not to, even in a place like this.

> Laughing is important in our situation because it can be so sad. In my experience, there is a close relationship between tears and laughter.

INTERSECTING LINES

Looking into the women's face
I could see the lines intersecting,
lines of laughter and lines of despair,
criss-crossing to form a pattern on her skin.

The way they came together so naturally,
it was apparent they had met often before.

Sharing the lighter side of life on a cancer unit requires impeccable sensitivity and tact on the part of the nurse. Julie commented,

> We use humor delicately. It requires a careful matching of types of humor with specific patients and situations. I consider it carefully. I think what kind of humor this patient would like, or would they be open to it at all. When you use humor is important too. Timing is critical.

As Hunt (1993) cautions, "Individuals have differences in what they experience as humor. Individuals also have religious preferences, cultural experiences, and unique values that make certain kinds of humor unacceptable" (p. 35). She continues saying, "Careful nursing assessment [should] be done prior to utilizing humor" (p. 37)..."like any other intervention strategy, there are indications for, limits to, and contraindications for the use of humor" (p. 34). Pasquali (1990) warns that humor is inappropriate when it ignores client humor styles, ridicules, is racist or sarcastic.

Jane observed, "When using humor it is important to determine what is appropriate and what is not. I am very careful when the patient is in pain, suffering, confused, or depressed. At these times it might not be helpful to laugh or be playful." Blondis and Jackson (1982) agree and caution, "When using humor, use not only what is comfortable for you, but what is acceptable to the other person" (p. 189). Baughman (1974) advises that to be effective, humor must to appropriate to the audience and the situation.

In summary, a definition of this approach to life reveals that although humor and laughter are part of a light-hearted attitude, it goes beyond these elements and is more complex and comprehensive in nature. It includes both verbal and non-verbal components, enactment is a deliberate choice, and it can be appropriate in circumstances that are tragic if it is used with sensitivity.

THE VALUE OF SHARING THE LIGHTER SIDE

In reviewing the data related to the lighter side of nursing care it appears this attitude serves four major purposes. It enhances communication, carries out a social purpose, achieves a psychological value, and performs a therapeutic role. Each of these will be described in the following sub-sections.

Communication Function

> "But most of all, we laugh."
> (Leacock, 1938, p. 12)

Communication is an important component of being human. In the words of Bassett and Smythe (1979), "communication occurs whenever people assign meaning to each other's behaviors" (p. 5). According to Thomas (1983) humor communicates a mood, establishes a tone, and develops an attitude in both parties.

Humor, laughter, and the attitude described were used by the nurses to communicate important messages to the patients. As Thomas (1983) recognizes, humor serves as an extension of oneself into the patient's situation. Lana said, "When you have this kind of approach to life, where you see the positive in things, you laugh easily, and smile a lot; it tells patients you are a person who is willing to share their lives, their troubles, their joys."

This memory is an example of such a message communicated:

> Jerry had been diagnosed with acute leukemia for over a year. As with most patients who receive many courses of chemotherapy, we had developed a strong relationship with Jerry and his wife. Jerry was originally from Scotland and spoke with a thick Scottish accent. He referred to all the nurses as "sweetheart," and that was fine with us. His sense of humor was always present and he was quick to share a joke with a receptive person.
>
> Jerry was in remission and was supposed to have a potentially life-saving bone marrow transplant in Toronto. However, his brother, who was expected to be the donor, was found to have incompatible marrow. The transplant, his last hope for a long and healthy life, was cancelled.
>
> This was his first admission since his disappointing trip to Toronto and the nursing staff were unsure of how to approach him. I was no different, and walking down the hall to his room was one of the most difficult walks I have made. I took a deep breath and entered his room. He was the first to acknowledge my presence. "Hi sweetheart," he said. "I'm back."
>
> I looked at him, smiled, and said, "Don't tell me Jerry, the nurses in Toronto didn't laugh at your jokes so you had to come home."
>
> With that Jerry started to laugh. "You're right," he

said. "I missed you girls." That was all it took to break the tension. At that point I sat next to him on his bed and listened as he told me of his trip, his disappointment, and his hopes for the future.

ENTERING YOUR EXPERIENCE

Shared laughter
is a conduit into your experience.
It rivets us together,
so for an instant
we understand.

Another nurse, Maureen, said about laughing with a patient,

> I think it signals to the patients that you have time for them, time for more than the nursing procedures I mean. If you joke around with them, it means you value them. They are worthy of your time and attention.

Humor was sometimes used by the nurses studied when the messages to be communicated were very serious and emotion laden. In these situations, the direct expression would have been uncomfortable for both the nurse and patient. In the following scenario, taken from my field notes, the light-hearted approach was used to communicate information indirectly. Though the meaning was concealed, the patient understood.

> It was late at night and a distraught patient rang her bell and asked the nurse I was observing for an anti-anxiety medication. After assessing the situation, the nurse determined that such a medication would not be appropriate in this patient's circumstances because it could hasten death. To communicate this message to the patient the nurse gently said, "Mrs. James I'm afraid to give you the pill you asked for because it would make you sleep - sleep too long." For a moment there was silence, and then the patient understood this delicately worded message and they both smiled.

Outside the room the nurse, Julie, offered this analysis of the situation.

> I believe in always telling patients the truth, but sometimes it's just too brutal to say it outright. What was I supposed to say to her, "If I give you the pill you want it will probably kill you." I just couldn't put it that way. The joking approach is better, especially when the topic is such a heavy one.

THE MOURNFUL LAUGH

Sometimes
the topics that are the most
laughable
are those that are so somber and sad
that ordinary words can't do them justice.

"Laughter," Moria said, "almost always precedes the tears. It somehow opens the gateway, allowing for meaningful communication of the real issues." Moody (1978) puts it this way: "Humor is an important pass key into an environment in which the locks are always changing" (p. 120). Clearly, a light-hearted approach can enhance the communication function.

Social Purpose

Sharing the lighter moments is part of creating a bond between the nurse and patient. As Jane said in an interview,

> When you spend time with your patients laughing and joking together, it tells them that you want to share something of yourself with them; and you get to know another part of them too. This makes you friends in a way. It gives a sense of solidarity.

Blondis and Jackson (1982) support this belief with their contribution that, "Humor helps establish relationships. If we can laugh together, I'm your friend" (p. 188). Julie commented, "You are acknowledging a person when you laugh appropriately. You are saying, `Yes, I understand what you are saying'."

Julie shared the following story which illustrates the social bonding that can occur between nurse and patient and the patient's family members through humor.

> I enjoy laughing with my patients, but one of my unforgettable moments began by being laughed at. The patient was newly admitted. He did not want to be here, he wanted to die at home. After all, he owned a funeral home and he knew about dying. He seemed to have a dozen children. They really didn't want him here either. Each was dealing with their guilt and hurt in their own way. The room was always packed with people, but it was not necessarily a friendly place to be.
>
> When I walked in, the hostility was acrid, but my name-tag said nurse and that gave me licence to be there. Besides, the man was definitely end-stage and it would have been totally wrong for him to die without even having his blood pressure recorded! So in a feeble attempt to give him care, that's what I did, I took his pressure.
>
> As my stethoscope was plugging my ears, I only picked up pieces of a conversation that was occurring in the room around me. "I don't think she could walk this far." "Maybe they have visiting hours." "She's old you know, and so fat."
>
> Having finally found his blood pressure and wanting to make a significant contribution to the overheard puzzle pieces, I very innocently said, "I couldn't help overhearing. If there's anything we can do to help with the visit we would be glad to. We have wheelchairs. Feel free to borrow one."
>
> Whereupon the room was filled to overflowing with gales of laughter. One fellow even fell weak-kneed into a chair. Tissues that once held tears of sadness were now wiping away drops of hilarity. It turned out the elderly, crippled, maiden aunt that I had envisioned was an old arthritic overweight English bulldog who probably wouldn't have even fit in the wheelchair!!
>
> Yes, the dog did visit. In fact, she monopolized the patient's bed, by this time far outweighing her cachexic master. There were many more smiles and yes, many more tears, both happy and sad, but the bond created by the original faux pas remained strong.

SOCIAL CLIMATE CHANGE

Laughing together
makes the social climate,
summer or winter,
ideal.

I watched the exceptionally competent nurses use humor and playfulness in their actions and voices to help them build relationships almost instantly with patients. On one occasion as we entered the room of a new patient carrying a bag of intravenous solution the nurse said, "Hi, I'm your nurse, the bag lady." The patient and visitors laughed because this well-dressed, poised, carefully groomed woman was obviously not a bag lady. My field note reads, "They laughed together at the absurdity of the comment and as they laughed the tension in the room eased and the door was opened for important serious exchanges."

The literature also suggests that sharing humor helps establish relationships and aids in creating rapport. Julie talked about this when she said,

> There is a sense of cohesion that develops when you share inside jokes with someone. I do this with my patients, and also with the other staff members. For example, we have certain abbreviations that we use that no one else knows the meaning of, like FOS and PON. When we say these code words in report it makes us laugh, it makes us a team, special somehow because only we know the meaning.

Both the care-givers and the patients are initiators of humor, especially for social purposes. Jane told me she gives her patients permission to joke and laugh by her example. She remembered with delight one patient who followed her lead.

> He rang his bell and when I asked him how I could help he said, "Well, I just washed my hair and I can't do a thing with it." It was really funny because he only had one or two hairs left, he had lost almost all of his hair from chemotherapy. We both laughed. At that moment I felt very close to him and I am sure he could tell that I cared.

Julie said, "The patients really seem to enjoy the atmosphere around here. They tell us jokes sometimes. The other day one man told me the rankest joke, it was so bad I really didn't understand it..., but it made us laugh."

Baughman (1974) describes humor as a "social lubricant." It eases social situations, and promotes smooth and comfortable social interaction. He concludes humor helps to establish relationships, decrease fears, encourage trust, increase the feeling of friendship, and decrease the social distance as it invites others to come close.

In observing embarrassing moments and errors made I noticed that humor was often used to "lubricate" these situations. For example, one day in the unit Mindy discovered that a patient had not been assigned a nurse and had gone through part of the day without care. The nurse who had made the error was remorseful. Instead of becoming angry or agitated, Mindy just said, "I guess God had him this morning." The situation was resolved, no harm had come to the patient, and a lesson was learned, while the light atmosphere was maintained. Kane, Suls, and Tedescki (1977) suggest that humor helps resolve potentially disastrous social interactions by trivializing potentially serious incidents and helping one save face.

I observed nurses using humor when carrying out procedures that were potentially embarrassing or humiliating for the patient. In one instance Julie had just given a very small, fragile, shy man an enema which had been very effective. The patient was uncomfortable with the process until Julie lightened the scene when she exclaimed, "Why Mr. Godfree, I didn't know you weighed that much." On a similar occasion she said to the patient with a smile, "You done good, buddy."

Nurses who exhibit this sense of light-heartedness convey to others a warmth, friendliness, and acceptance. This probably affects how others perceive them. It makes them seem real, human, and approachable, the kind of people you chose to trust with your problems and feelings.

In the book It's a Funny Thing, Humor Kane, Suls, and Tedescki (1977) describe qualities of humor that make it important in effective nurse-patient interaction. Humor allows the nurse to probe, to find out more about the patient's feelings and fears without taking real risk. In this way humor has an unmasking quality. According to these authors, humor moves people toward intimacy, it is an invitation to interact on a more personal level.

FUNNY THING ABOUT LAUGHTER

When we laugh together,
it somehow shortens the distance between us,
it reduces the space we occupy,
but doesn't make it
any more crowded.

Psychological Value

Baughman (1974) quipped, "Humor is like a diaper change. It doesn't solve any problems permanently.... It just makes life a bit more comfortable for awhile" (p. 61).

Moody (1978) said, "Humor itself is one of the good things of life...to dispense laughter to someone would be to increase the quality of this life" (p. 120). As Thomas (1983) comments humor animates and provides a change of pace. For these reasons, and others, sharing the lighter side of life offers a psychological value for patients and staff.

The nurses in the study believe that sharing moments of lightness helps to comfort patients. Both the nurses and the patients commonly exchanged old jokes that had long since ceased being funny. The patients would say, "I suppose you are going to wake me up to give me a sleeping pill," or the nurse would jest, "You must be feeling like a pin cushion," and both the patients and nurses would laugh. I believe there is some comfort in laughing at these tired jokes. It is analogous to putting on well-worn slippers; it just feels good. If one is still laughing at the same routine, this signals that things are fine, that nothing has changed. Perhaps it is important that they are old jokes and their familiarity is a comfort.

Blondis and Jackson (1982) identify humor as a safety value, a mechanism used to release stress. Baughman (1974) explains how this happens: "Laughter eases aggression, anger, and distress by taking one's mind off the situation at hand by casting a different interpretation of life" (p. 56).

Lana, in describing how laughter eased the tension in a situation she encountered said, "Somehow even a little titter decreases the intensity of the moment, and makes it so we can carry on." This effect of humor was demonstrated by a nurse-patient encounter I witnessed and recorded.

> I was watching as the nurse was trying to talk a patient into having a bath she was refusing to take. The nurse had used a variety of approaches aimed at persuading the patient that a bath was in her best interest. At the precise moment when the scene could have become uncomfortable for the patient, nurse, and visitors, the nurse said, "That's the problem with nurses. If all else fails we wash it." Everyone laughed, the tension eased and the woman consented to the bath.

During another conversation Julie told me this story about laughter easing tension.

> Sometimes the responses I get are more expressions of shock from the patients, but it really relieves the tension when you can get a laugh. Yesterday I was looking around for some tube sites on this fellow. The records hadn't been updated so I didn't know for sure where on his body the tubes could be found. As I fumbled around peeking inside his pajama tops and bottoms I said, "I think you should put me up for sexual harassment." The patient laughed and I enjoyed it. It put a lightness into the situation. It covered my incompetence and I think, no I know, it made the patient more comfortable with what I was doing.

A light-hearted attitude also helps to develop an environment that is warm and nurturing, which is a psychological benefit. It also inspires hope. Moria indicated, "I think the patients like it when we laugh with them. I think they believe that if we are still laughing everything is still O.K. It is reassuring, it gives them hope." As Lana said, "A sense of playfulness opens up discussion, breaks the cycle of despair and fosters hope, because if you can laugh you are still alive."

Bradford (1964) reports,

> Humor not only brightens, it cleanses the common life.... It is always on the side of hope, high hope. It is always on the side of promise. It asserts that the sun still shines, however dismal the weather of the moment, that the morning birds still sing, and what is more, that there is something to sing about. (p. 70)

In summary, a light-hearted attitude helps to relieve anxiety and tension on the unit. It is a positive outlet for frustration and lightens the heaviness of critical situations. As Jane commented, "When we laugh it lightens the moment, it provides balance and hope." She called her attitude, her "survival kit."

Therapeutic Goals

Gelazis (1991) claims, "Humor can be an important part of caring for clients, caring for other nurses, and caring for ourselves" (p. 160). On one occasion in the field, the nurse I was observing, Julie, had encountered a novice nurse performing a procedure incorrectly. She had intervened to prevent danger to the patient and in doing so had caused the other nurse some personal embarrassment and distress. Later that shift Julie used humor to re-establish connections with her young colleague. The field note reads,

> For the second time tonight we come across Janell having trouble with technology. This time she can't get an

> infusion pump to start. As we approach her, apprehension is apparent. She doesn't want to make another mistake and her anxiety makes her fumble inappropriately with the machine. Julie gently gives guidance saying, "Press A, then B, and it helps if you say the right prayer." Janell follows the directions and the machine starts running. Julie smiles and says, "See you must have said just the right prayer." They both laugh and a less flustered Janell is able to carry on.

THE FORGIVING LAUGH

It is hard for you to laugh with me
and still carry your anger.
Your smile tells me in such a clear way
that I have been reinstated,
that I am once again your friend.

On another occasion a nurse came up to Julie, the nurse I was observing, to report an error that she had made. Julie just smiled and said, "That's O.K., we try harder than most. But who can we blame? At times like this it is nice to have someone to blame. It must have been the wandering nurse." During that shift the "wandering nurse" became the scapegoat for a variety of problems including noxious odors and misplaced coffee cups.

I asked the Julie about this situation in a conversation. She explained,

> You have to know which things to deal with seriously, and which situations you can let go. That wasn't an error worth making a big deal about...so I made a joke out of it. It made her feel much better, and I know she learned more than she would have if I'd given her the big lecture.

A light-hearted attitude helps one meet unexpected events in the course of life (Reader, 1991). Baughman (1974) describes a humorous attitude as a tonic which invigorates and stimulates the recipient. The nurses provided examples of this effect of humor and laughter; they argued that it provides refreshment and restoration for them as well as for the patients. Marie said, "laughter in a room, just fills the room with energy." Jane commented, "laughter makes the world less drab somehow, and more human, much more human." Gruner (1978) agrees saying, "Human societies treasure laughter and whatever can produce it. Without laughter everyday living becomes drab and lifeless; life would seem hardly human at all without it" (p. 1).

In some situations humor seemed to help ease the pain of patients who were experiencing it. Several researchers, including Moody (1978) have written claims that humor does reduce physical pain. They believe that this is an important application of humor. According to Moody (1978) "Humor draws attention from pain" (p. 112), bringing relief. However, a comprehensive analysis of this therapeutic function of humor was beyond the scope of this study.

In summary, Baughman (1974) explains the therapeutic function of humor in this way, "It creates happiness, fosters friendship, cheers the discouraged, and dissolves tensions. And as a bonus, it frees the mind, oils the squeaks, and enables us to carry on with fewer dark hours" (p. 52).

THE VALUE OF A LAUGH

Laughter turns on the lights.

It is a defense against
panic,
sorrow,
and darkness.

It helps tide us over
until dawn.

FORMS OF HUMOR OBSERVED

What is humor? Why do we laugh? There are descriptions of several different forms of humor in the literature. Many of these forms of humor were observed during my field work. Word play, use of the humor intrinsic to the situation, surprise, divergent humor, and black or gallows humor were some of the common forms. Each of these is addressed in turn in the sections that follow.

As mentioned earlier, the nurses attempt to match their style of humor to what the patient appreciates. Jane said, "I change my style of humor to suit the person. I just push the buttons until I get a genuine response." In a field note I wrote, "She takes her humor cues from others as to the type of humor that is suitable, and then improvises." Julie explained,

> I probably read them quite quickly. It depends, but I usually try it out when I am alone with them rather than when their families are there because the families may be shocked if I am too familiar. The families are tense, especially at the beginning. I usually use humor after the patient has been here for a while.

Surprise Humor

Marie often used surprise in her approach to humor. In this style, surprise, shock, or the unexpected are conditions necessary for humor (Thomas, 1983). This story depicts Marie's use of a surprise style.

> My brand of humor is usually nice and dry, kind of subtle. This patient I am remembering was diagnosed with a head and neck cancer. He had a history of alcohol abuse. He was impossible. I guess I got the short straw at assignment time and he was all mine. He was gruff, rude, verbally abusive...a real gem. What's more, he required trach. care, suctioning, and instillations. A perfect nurse-patient bonding activity.
>
> I remember tip-toeing into his room hoping he'd sleep through my evening shift. Hardly, he was waiting for me in dire need of suctioning, since he probably refused care from the respiratory therapist on days. Using humor was far from my mind at first. There was nothing he was going to find humorous and I knew it. I was very professional with him and I scraped by for two shifts. But, I had seven consecutive evening shifts scheduled and I realized for the sake of patient-nurse continuity he should be mine for all seven evenings.
>
> By the third shift we had become more familiar with each other. I thought I'd try it. When I entered the room, I said, "Oh no, not you again," and rolled my eyes back in my head. I think my approach shocked him. He didn't expect a statement like that from such a "professional" nurse. Soon, he mimicked my actions, rolling his eyes back into his head when I entered his room. By the fifth shift he broke into a smile, and I got a wink of the eye by the sixth. He and I were eager to see each other by my last shift and shared a few jokes. He did in fact request my care in future trach. procedures. Ah, this I count as success!

In another incident where surprise was used, a patient called the nurse, Jane, into his room. When she entered his room his usually bald head was covered in a curly, long, blond women's wig. The patient looked at the nurse and said, "Notice anything different?" The element of shock and surprise caused them to laugh together for a long time.

Finally, Maureen told me a story in which her own shock response to the patient helped to dissipate the patient's anger.

> A patient slipped and fell on the floor. She overheard one of the nurses commenting that it happened at shift change. The patient got upset thinking that because of the timing of the fall, at change of shift, the nurses might have ignored her there on the floor until report was over and the replacement nurses were on duty.
>
> Well, I went and talked to her and basically for half an hour I just listened to what she had to say and acknowledged that it was upsetting to think she might have been left on the floor. Then we started talking about other things and I leaned over to her and said, "Next time, just make sure you don't fall at shift change!" She just started really laughing. Over the half hour I figured out that she was quite a character and I knew she would respond to that kind of humor.

Word Play Humor

Jane used word play, rhyming words, and lines from songs when providing care. These were a natural additive to her conversations with patients and others. Talking to a patient one day about his diarrhea, she rhymed, "It's just like the musical fruit, down your leg and into your boot." Entering a patient's room to bring him his noon meal she said, "How would you like a bunch of lunch to munch and crunch?" Her poems and quips did not necessarily fit the context precisely, but the lyrical cadence of her voice was playful and reassuring.

Black Humor

Black humor was used often among staff members, usually in places that were isolated from the patients and family members. During team conferences, in the medication room, and during report, nurses and other care-providers found a release of tension through humor that was dark and gruesome. Maureen explained, "The staff often use black humor, in the med. room especially. We would never ever share what we talk about in there with the patients." For example, a physician was observed seriously advising the nurse who was caring for a man whose colostomy just would not stop, that he had ordered the same patient two doses of laxative. In another situation Moria advised her team-mates in jest that she was going home early today because "all of her patients were in the morgue." In fact, two of her four patients had died that day.

A field note provides a further example of the staff using black humor.

> A Catholic priest stopped to tell the nurse in charge, whom I was observing, that the patient he had been called to see did not wish to see him because he was Catholic. The nurse, Julie, said with a straight face, "I suppose she just swore at you and told you to take your cross and go home!"

Black humor serves many social functions. Julie explained, "It helps to build the atmosphere of team-work, like we are all in this together. It's easier to work with people you laugh with." Jane shared this view, "The black humor relieves stress. We laugh so we don't cry. We laugh so we can cry."

Situational Humor

Situational humor may be rooted in the nurse's or patient's actions or discomforts. The bed pan that spills, the water jug that tips over, these situations that could lead to other negative emotions and consequences are turned into positive experiences by finding the humor in the event. One day as we entered a patient's room with ice water in hand, the nurse, Jane, tripped over a stool on the floor and flung the water jug into the patient's lap. The patient who could have become upset, just smiled a crooked smile and said, "Well at least I'm awake now."

Situational humor humanizes the environment. The nurse and patient involved in such a situation touch each other with humor. Together they help one another cope with the unexpected.

During a conversation Julie said,

> Most of the time it is just the situation. Usually it is just spontaneous because some things that happen are really funny. Like the other day one of the doctors wrote an order that said, "Keep trying to get the patient to suck on his balls three times per day." He meant have him use his incentive spirometer machine, but when we read the order we just totally lost it.

Divergent Humor

Spiegel (1972) describes the divergent approach to humor as "humor arising from disjointed, ill-suited pairing of ideas or situations or presentations of ideas or situations that are divergent from habitual customs" (p.

7). An example of divergent humor is contained in a commonly heard standing joke in the unit, "Around here, two club sodas equals a party."

A field note provides another example of divergent humor.

> A patient's daughter had made multiple trips back and forth in front of the nursing station moving in her Mom's personal belongings. Finally, the daughter said to the nurse I was watching, "That's the last load, just a couple of cases of beer to go." Without hesitation, the nurse replied, "Good, let's put it in the fridge."

Another field note recalls an equally revealing example of divergent humor.

> Coming down the hallway towards us was a tiny elderly lady. Her gait was so unsteady she was at risk for a fall. Maintaining her calm demeanor, the nurse, Julie, approached the woman and taking her securely by the arm said, "If the police saw you they would arrest you for impaired driving, let's get you to a wheelchair." They both laughed at the proposterousness of this innocent, angelic grandmother being arrested for anything.

On another occasion, two nurses were discussing possible interventions to assist a very agitated bed-ridden patient. After seriously considering several alternatives without success, Peter lightened the situation by saying, "That man used to be a carpenter, can't we give him a wall to knock down or something." The image of this very ill man doing something as physical as hospital renovations was very humorous. The laughter stimulated further productive discussions focused on solving the problem.

DEVELOPING THE ATTITUDE

Gelazis (1991) contends that, nurses have been taught and socialized to maintain a serious demeanor while caring for patients. Humor calls for genuineness and the ability to be yourself, to shed some of this indoctrination.

Hunt (1993) claims that humor is a skill and thus can be learned (p. 37). The nurses in this study agreed that the light-hearted attitude can be developed and practiced. Lana said, "Developing a sense of the humorous begins by learning to laugh at yourself." Baughman (1974) explains that people who can laugh at themselves will always be amused (p. 52) and Gelazis adds that, "Laughing at oneself has been associated with maturity.... It is a use of oneself as the primary instrument of healing" (1991, p. 259).

Our sense of humor evolves. As Steven Leacock (1938) the well-known Canadian humorist observed over half a century ago, "Both the sense of humor and the expression of it undergoes, in the course of history, an upward and continuous process" (p. 8). The nurses were sensitive to this developmental change. Jane explained, "I can see a real change in myself and in my attitude over the years of nursing. Things I laugh about today, I would have cried about a few years ago. Now I can see the fun in things while I see the sadness." From Maltz's (1960) perspective this attitude can be built, like a muscle is developed, with exercise.

Benner and Wrubel (1989) conclude that humor can "reframe a situation; however, effective use of humor requires a deep background of understanding of the situation and at least a modicum of trust and respect" (p. 19). The nurses I observed had these qualities. They understood from their previous experiences how the patient might be feeling; they had developed trusting relationships with patients; they were respectful of the uniqueness of each individual and each situation; and they had cultivated in themselves a humorous attitude. Consequently, they were able to use humor appropriately and effectively as a nursing intervention.

Levine (1977) states, "When we adopt a humorous attitude we re-assert our invulnerability and refuse to submit to threat or fear" (p. 127). When we laugh at ourselves, we have a healthy perspective and are able to neutralize our shortcomings. By assuring a humorous attitude we open ourselves to the world and extend ourselves to others. We communicate a positive regard for patients.

CHAPTER SUMMARY

In chapter seven, sharing the lighter side of life, an attitude that involves seeing the positive or humorous in situations, was described. It was revealed that the exceptionally competent nurses studied exhibited this orientation to life and importantly, were able to share their outlook appropriately with colleagues and patients.

Several major elements were discussed and described in attempting to define this attitude. Most important, sharing the lighter side of life is more than telling funny stories and laughing zealously, it involves a deliberate choice to see the positive even in tragic circumstances.

This light-hearted approach to life and to nursing practice was seen to serve four main functions. First, it facilitates communication of messages and moods nurse to nurse and between nurse and patient. It was seem as a means by which the nurses could enter into their patients' experiences, while at the same time letting the patients know that they were available to them. The laughter and humor associated with this attitude often opened the doors for discussion of more serious issues.

Laughter and humor helped to form social bonds between the nurses studied and their colleagues and patients. Not only did it cultivate the establishment of relationships, it affected the social climate positively, and helped smooth over socially embarrassing moments.

Many of the stories and quotations suggested that this attitude also brought some physiological value. Generally, holding such an attitude made the situation more comfortable for the participants and increased the quality of life of those involved. Decreasing stress and relieving the strain of intense moments were both facilitated when nurses exhibited the light-hearted approach in situations.

Several unanswered questions remain regarding the therapeutic use of humor and a positive attitude. However, as a general observation it was seen to refresh both the patients and the nurses at the study site and to reduce psychological pain.

There are many forms of humor that were used by those nurses who exhibited this light-hearted orientation. Specifically, examples of divergent, surprise, word play, black, and situational humor were explored. Most importantly, these nurses matched the form of humor they used to the patient and the circumstances.

Finally, it was agreed by the nurses studied and by several researchers who have written about humor that the light-hearted attitude can be developed and that it changes over time. Self-awareness and a degree of self-confidence that allows people to laugh at themselves is the first step in this process. Through maturation, experience, and introspection the nurses in this study developed their light-hearted attitude.

REFLECTIONS ON SHARING THE LIGHTER SIDE OF LIFE, MUTUAL TOUCH, AND THE DIALOGUE OF SILENCE

All three of the themes identified - dialogue of silence, mutual touch, and sharing the lighter side of life - share commonalities. Using these approaches involves both the patient and the nurse. They are inter-personal exchanges that are experienced by the participants together. Both parties are affected by the action or the attitude. It is not a matter of one doing to the other; it is a shared experience, doing with one another.

These are, or enhance, avenues of communication.

Messages are sent instantaneously and simultaneously from person to person. They are all means by which the nurses enter their patients' worlds and share some of their experiences.

The complexity and universality of each theme is evident. This brief synopsis of observations and analysis cannot capture fully the intricacy of the myriad of approaches to patient care. However, it is possible that the stories, poems, and narratives leave us with a greater insight than we had.

These are all qualities and forces that are felt, that cannot be measured. As Leacock (1938) said, "You cannot weight an argument in a balance, measure social forces with a slide rule, or resolve humor with a stethoscope" (p. 8). I believe this is the case for silence and touch as well.

Finally, they all expose a basic honesty. Through touch, silence, and laughter, a part of each person comes into view, no longer hidden from the other. This opening of the spirit of the nurse and patient allows care to be given and care to be received.

THE CAN OPENERS

Touch, laughter, silence,
these are can openers
to your spirit.

They pry off the lid
to your soul
and let me peak inside.

Chapter 8

TOWARD A GROUNDED THEORY ANALYSIS

CHAPTER INTRODUCTION

As described in the second chapter, this dissertation includes both hermeneutic and grounded theory analysis. To this point in the description of findings the hermeneutic analysis has been featured. Chapter 8 describes a beginning grounded theory analysis of the data.

This chapter is divided into several sub-sections. First, a brief review of the advantages and disadvantages of combining grounded theory and hermeneutic analysis is provided. Second, the specific components of grounded theory analysis are described, including a discussion of techniques for enhancing theoretical sensitivity. Next, in turn, open, axial, and parts of the selective coding approaches are described and examples of their application to the data are provided. The culmination of the selective coding discussion is the presentation of a descriptive story line and the identification and description of the core variable.

COMBINING GROUNDED THEORY AND HERMENEUTIC ANALYSIS

With some elaboration this grounded theory analysis could stand alone as a beginning assessment of the data, but when it is combined with a hermeneutic analysis, a fuller understanding of the phenomenon of exceptionally competent nursing practice is possible. The grounded theory analysis provides a more conceptual understanding, while the hermeneutic exploration furnishes the descriptive element. Thus, the coding and categorizations of grounded theory can be said to provide the lines of the picture, with the hermeneutic analysis giving it color.

It was useful, for several reasons, to conduct a second analysis of the same data using the grounded theory process. First, a second look from a new perspective provided additional insights, and helped me recognize the processes that I had used to discover so readily the three themes discussed in Chapters 5, 6, and 7.

Second, it facilitated my understanding of the meaning of some of the stories and observations that I had not included in the earlier chapters. The theme of these "left-over" data was not clear to me until I conducted the grounded theory analysis. What emerged through grounded theory coding is the category I called the effects of nursing actions and interactions. Included in this category are the sub-categories of affirmation of value, connecting, and joint transcendence.

Third, the grounded theory analysis helped me organize and categorize data. It caused me to ask questions about the possible linkages between categories and to create an overall story about how these categories might fit together. The possibilities for further research became more clear as I raised questions that were unanswerable from the research I had done.

Fourth, the grounded theory analysis involves some data that have already been discussed in preceding chapters. Consequently, this chapter provides a summary and expansion of the earlier analysis.

Finally, the grounded theory analysis goes beyond the earlier discussions and encompasses a further search for the core variable, the fundamental meaning in this human experience. For these reasons, the work in this chapter makes a new contribution.

Although the grounded theory analysis was a useful exercise, I did find the process very structured and limiting. At times it seemed unnatural making data about such a vague phenomenon fit the coding structures prescribed. As admitted by Strauss and Corbin (1990) much of the coding process is automatic to an inquisitive person, so it requires some perseverance to analyze the data by this methodical approach.

BACKGROUND TO GROUNDED THEORY ANALYSIS

As described in Chapter 2, a grounded theory is "one that is inductively derived from the study of the phenomenon it represents" (Strauss & Corbin, 1990, p. 23). In grounded theory research the goal is to "discover relevant categories and the relationships among them; to put together categories in new, rather than standard ways" (Strauss & Corbin, 1990, p. 49). Grounded theorists believe that through a systematic collection and analysis of data using specific coding procedures a theory may be discovered, developed, and preliminarily verified.

Strauss and Corbin (1990) present three levels of coding: open, axial, and selective, where "coding represents the operations by which data are broken down, conceptualized, and put back together in new ways" (p. 57). Open and axial coding are used if the research goal is description of the phenomenon, theme analysis, or concept development; selective coding is the process that leads to theory generation and verification. Strauss and Corbin (1990) claim that the results of open and axial coding alone provide useful insights.

According to Strauss and Corbin (1990) there are several levels of analysis possible with grounded theory method (p. 159). Chenitz and Swanson (1984) agree saying, "Grounded theory research findings can be reported at different levels of detail and abstraction, ranging from presentation of the theory, to explanation of selected propositions, to description of a category or concept" (p. 150).

Swanson (1986) states that many reports using grounded theory describe categories derived from the data. In her opinion, "These reports are valid and are needed as building blocks. From these...hypotheses may be generated that can lead to the eventual linking of categories and the generation of grounded theory" (p. 122).

Strauss and Corbin (1990) emphasize that the distinctions between each type of coding are somewhat artificial. "In a single coding session, you might quickly and without self-consciousness move between one form of coding and another, especially between open and axial coding" (p. 58). They explain that, "Much of what should happen when coding happens automatically," however they recommend doing the coding purposefully, following specified procedures in order to "capture as much complexity and movement in the real world that is possible, while knowing we are never able to grasp all of it" (p. 111).

Two analytic procedures, making comparisons and asking questions, are basic to all the coding processes. Consequently, Glaser and Strauss (1967), the originators of this technique, called grounded theory the "constant comparative method of analysis" (p. 67).

This chapter includes a beginning grounded theory analysis using the coding procedures specified by Strauss and Corbin (1990). The categories developed in open coding help to organize the data. During axial coding the categories are linked together illustrating some of the multiple processes that occur in the phenomenon under study. A preliminary selective coding explicates a descriptive story line that summarizes the major findings and begins to define the core category. The findings revealed by categorization and conceptualization of the data add to our understanding of exceptionally competent nursing practice.

Enhancing Theoretical Sensitivity

Strauss and Corbin (1990) stress the importance of researcher "theoretical sensitivity." They contend that, "Researchers often fail to see what is there because they come to analytic sessions wearing blinders, composed of assumptions, experience, and immersion in the literature" (p. 75). Researchers who have "theoretical sensitivity" are able to see with analytic depth what is there (Strauss & Corbin, 1990, p. 76).

Theoretical sensitivity can be enhanced, according to Strauss and Corbin (1990), with questioning, turning a concept upside down and imagining the opposite, systematic comparison of two or more phenomena, and being sensitive to certain words and phrases like "never" and "always." They counsel, "Do not take anything for granted, the minute you do, you close a possibility that may be the key to uncovering the answer to one of your research problems" (p. 93). I attempted to enhance my analysis by paying heed to their advice and using the techniques they recommended during analytic sessions.

OPEN CODING

Strauss and Corbin (1990) explain that, "Open coding involves naming and categorizing of phenomena through close examination of data. During open coding the data are broken down into discrete parts, closely examined, compared for similarities or differences, and questions are asked about the phenomena" (p. 62). Each discrete incident, idea, or event is given a name that represents that phenomenon. This is called "labelling phenomena" (Strauss & Corbin, 1990, p. 63). As the analysis proceeds, incident is compared with incident so that similar phenomena are given the same name. The end-product of open coding is a list of labelled phenomena called concepts.

I proceeded line-by-line through the transcripts of interviews and the field notes finding and labelling concepts. Following Corbin's (1986) recommendation, I underlined the incidents, events, and key words I encountered, and then wrote a more abstract description or code for what was happening in the margin. As I progressed I asked two questions, "What was the nurse doing in this situation?" and "What was the effect of this interaction/action?" According to Corbin (1986) asking such questions keeps the researcher focused on the phenomena under study.

Working through the data again, I looked at larger sections of the material, asking myself, "What is the major idea brought out in this story or moment observed?" This second review was useful after I had determined the categories. It allowed me to re-evaluate what I had included in each category when employing the earlier line-by-line method.

A list of more than 200 concepts resulted from the first open coding assessment. As I reviewed them I readily determined that sometimes slightly different words were used for the same phenomenon. For example, I used playfulness and zestful to describe certain nursing actions. These I combined under the same label, lightness.

Despite this fine-tuning of my list I was still left with a number of words and phrases that were not ordered in any meaningful way. Following the explanation and direction of Strauss and Corbin (1990) I clustered these concepts around phenomena. "The process of grouping concepts that seem to pertain to the same phenomena is called categorization" (Strauss & Corbin, 1990, p. 65).

Four categories resulted. These were given more abstract names than the concepts placed into them. The concepts provided a description of the properties (characteristics, attributes, and traits) of each category. Again I attempted to reduce the number of concepts by placing those that might be similar together, such as supportive, nurturing, comforting, and empathetic. Within each category, naturally occurring sub-categories became apparent.

To demonstrate this process I have included a description of the four categories and the concepts included in each of them. According the Chenitz and Swanson (1986) categories are the link between data and theory and are important for the description and initial analysis of qualitative data.

I. Category One - Attributes of These Exceptionally Competent Nurses

A. SUB-CATEGORY - QUALITIES OF THESE EXCEPTIONALLY COMPETENT NURSES

- caring/concerned
- supportive/empathetic/nurturing/comforting
- reflective
- flexible
- appropriate/tactful/good timing/confrontational if necessary
- intuitive/sensitive
- patient/attentive to details
- radiant/energetic/smiling eyes
- lightness
- knowledgeable regarding
  - cancer the disease
  - human interactions
  - nursing skills
- totally well (or working toward it)
  - physically
  - spiritually
  - emotionally
- confident
- well-groomed
- committed
- interdependent
- authentic

B. SUB-CATEGORY - EXPRESSED VALUES OF THESE EXCEPTIONALLY COMPETENT NURSES

- honesty/genuineness
- ongoing personal and professional growth and learning

II. Category Two - Beliefs of These Exceptionally Competent Nurses

A. SUB-CATEGORY - BELIEFS ABOUT SELF

- multifaceted being
- importance of self-awareness
- importance of a life beyond work

B. SUB-CATEGORY - BELIEFS ABOUT LIFE

- quality of life versus quantity of life
- sacredness of life
- existence of a higher being

C. SUB-CATEGORY - BELIEFS ABOUT DEATH

- communality of birth and death
- confronting death enhances appreciation of life

D. SUB-CATEGORY - BELIEFS ABOUT NURSING

- important work/makes a difference
- goal-directed/intentional
- patient-centered

E. SUB-CATEGORY - BELIEFS ABOUT THE NURSING MILIEU

- depersonalizing, minimized if home-like
- energy forces present
- multifaceted - extremes of emotion (despair and joy), potentially overwhelming, sense of urgency

F. SUB-CATEGORY - BELIEFS ABOUT THE NURSE-PATIENT RELATIONSHIP

- intimate interpersonal relationship/physical and emotional closeness
- patient is primary/respected/valued/director of care
- trust is vital
- multifaceted/individual differences respected
- relationship mutually beneficial

G. SUB-CATEGORY - BELIEFS ABOUT HEALTH

- beyond absence of disease
- health without cure is possible
- multi-leveled
- disease can lead to greater health

H. SUB-CATEGORY - BELIEFS ABOUT HUMAN BEINGS

- multifaceted, including a soul
- each person has value
- each person has unique needs and perspectives
- people generally care about others

III. Category Three - Nursing Actions/Interactions

A. SUB-CATEGORY - METHOD OF COMMUNICATION
DIALOGUE OF SILENCE

  - useful in various circumstances
  - involves being there/staying there
  - involves listening with openness/understanding
  - multiple forms - silent messages in words, silent messages in actions, non-verbal messages framed in silence

B. SUB-CATEGORY - METHOD OF COMMUNICATION
MUTUAL TOUCH

- physical and emotional contact with patients
- multiple approaches - procedural, social, trigger, final, non-physical, diagnostic, comforting
- multiple qualities - soft, gentle, slow, reassuring

C. SUB-CATEGORY - METHOD OF COMMUNICATION
SHARING THE LIGHTER SIDE OF LIFE

- an attitude/philosophy of life
- humor/laughter/joking/teasing
- multiple audiences - colleagues, patients, family members
- multiple styles - word play, black, surprise, situational, divergent
- multiple purposes - entering the patient's experience, social bonding, therapeutic effects, psychological comforting

IV. Category Four - Effects of Nursing Actions and Interactions

Note: Sub-category A, B, and C are both actions and consequences

A. SUB-CATEGORY - CONNECTING (NURSE AND PATIENT)

- recognizing the similarities (overlapping realities)
- seeing the former you
- participating in patient's experience/involvement

B. SUB-CATEGORY - AFFIRMATION OF VALUE: ACKNOWLEDGING THE PATIENT

- helping the patient be remembered
- helping the patient create meaning out of the experience
- helping the patient maintain dignity and self-respect
- helping the patient see possibilities, find hope

C. SUB-CATEGORY - AFFIRMATION OF VALUE: ACKNOWLEDGING THE NURSE

- making a difference
- finding meaning in the experience (continued growth and challenge)

D. SUB-CATEGORY - JOINT TRANSCENDENCE

- continued growth of nurse and patient
- mutual transformation
- discovery of qualities not previously known in self

AXIAL CODING

According to Strauss and Corbin (1990), "Axial coding puts data back together in new ways by making connections between a category and its sub-categories" (p. 97). Some of axial coding occurs naturally during open coding. As these authorities on grounded theory state, it is difficult to separate the two processes precisely (Strauss & Corbin, 1990).

The method for accomplishing axial coding involves linking sub-categories to a category in a set of relationships using a structure described by Strauss and Corbin: (A) causal conditions lead to (B) phenomenon, which leads to (C) context, which leads to (D) intervening conditions, which lead to (E) action/interaction strategies, which lead to (F) consequences (1990, p. 99).

Each element in the structure follows from the one directly preceding it. For example, identifying the causal conditions leads to the development of a phenomenon, discovering the phenomenon leads to the context and so on.

Specifically, causal conditions are the events or incidents that lead to the development of a phenomenon. When asking the question, "What are these data referring to?", one discovers the central idea, event or happening which is the phenomenon.

The context, according to Strauss and Corbin (1990), "represents the specific set of properties that pertain to a phenomenon...[and the] particular set of conditions within which the action/interaction strategies are...carried out" (p. 101). Time, space, culture, economic status, history, and the nature of the organization are examples of intervening conditions that either facilitate or constrain the action strategies.

The action/interaction strategies are preformed in response to, or to manage, a phenomenon. Finally, the consequences are the outcomes of the actions. Strauss and Corbin (1990) observe, "Consequences of actions at one point...may become the conditions in another" (p. 106).

This structure was used repeatedly in an attempt to draw connections between various categories and sub-categories identified in the open coding process. Since the study took place largely in a single organizational environment, the specific elements included in the following analysis under context and intervening conditions are consistent for the three phenomena described. The consequences of all three phenomena are also the same, although each specific phenomenon led to actions and interactions that brought the effect about in different ways.

The results of some of these efforts to draw connections between various categories and sub-categories follow:

Example 1 - The Phenomenon of Sharing the Lighter Side of Life

(A) Causal Conditions - qualities of the nurses (lightness, energetic, radiant) and beliefs of the nurses (quality of life important, nurse-patient relationship primary)

(B) Phenomenon - sharing the lighter side of life

(C) Context - nature of the environment (extremes of emotion, despair and joy; potentially overwhelming)

(D) Intervening Conditions - Time (sense of urgency) and nurse-patient relationship (respect for individual differences)

(E) Actions/Interactions - appropriate use of different types of humor for various purposes

(F) Consequences - nurse-patient connection and affirmation of value (nurse is involved in patient's experience, patient feels important; if we laugh together we recognize and value one another); joint transcendence

Example 2 - The Phenomenon of Mutual Touch

(A) Causal Conditions - qualities of the nurses (concerned, caring, committed, supportive, empathetic, nurturing) and beliefs about patients (patient is primary, quality of life is important)

(B) Phenomenon - mutual touch

(C) Context - nature of the environment (extremes of emotion, joy and despair; potentially overwhelming) and nurse-patient relationship (intimate, physical and emotional closeness)

(D) Intervening Conditions - Time (sense of urgency) and nurse-patient relationship (respect for individual differences)

(E) Actions/Interactions - touching, physically and emotionally, in different ways for different needs and purposes

(F) Consequences - nurse-patient connection and affirmation of value (you cannot touch without also being touched); joint transcendence

Example 3 - The Phenomenon of Dialogue of Silence

(A) Causal Conditions - qualities of the nurses (supportive, empathetic, nurturing, caring, concerned, intuitive); values of the nurses (genuineness and honesty)

(B) Phenomenon - Dialogue of Silence

(C) Context - nature of the environment (extremes of emotion, joy and despair; potentially overwhelming)

(D) Intervening Conditions - time (sense of urgency); nurse-patient relationship (respect for individual differences, patient is primary)

(E) Actions/Interactions - communicating non-verbally, listening with openness, using silence in a variety of situations both emotionally charged and more ordinary to communicate caring and concern for the patient

(F) Consequences - Connecting/Affirmation of value of the patient and nurse; joint transcendence

Strauss and Corbin (1990) admit that it is difficult to capture the complexity of reality in such a structured and limited format. In my analysis I found that certain elements identified could be included in more that one part of this structure. For example, connecting and affirmation of value are both actions/interactions and consequences of other nursing actions. Connection and affirmation of value are part therefore, of both (E) and (F). In addition, as consequences affirmation of value and connecting may also be the motivation, or causal conditions for further action. I believe that the connection and affirmation of value, combined with the transcending experience enjoyed by the nurses becomes part of their motivation for continuing to give exceptional care.

I found using labels only to attempt to describe a phenomenon or a condition was incomplete. For me, the details could not be adequately captured without an accompanying narrative description. On each attempt to link categories or sub-categories using the structure, I felt I had to neglect many possibilities.

In one way this limitation is a strength of the method because it forces the researcher to make choices and to focus on what are possibly the most important discoveries. Using the model as a guide only, I was able to link the categories identified in open coding into schemes that were helpful in discovering what was really going on, the essentials of exceptional nursing practice. Strauss and Corbin (1990) call this identifying the story line. Developing the story line is the first step in selective coding.

SELECTIVE CODING

Selective coding, Strauss and Corbin's (1990) third level of analysis, involves making the leap between concepts and theory. Since generation of a complete and verified grounded theory is not the goal of this analysis, all the elements of selective coding were not completed. However, the first stages, explicating the story line, identifying the core variable, and determining the characteristics of the core were attempted. These exercises were helpful in coming to a greater understanding of what may be occurring in the practice of exceptionally competent nurses.

According to Strauss and Corbin (1990) explication of the story line involves "the conceptualization of a descriptive story about the central phenomenon of the story...when analyzed it becomes the core category" (p. 119). To write this story, the researcher asks the question, "What about this study is most striking?"

The Descriptive Story Line

In answering this question, a story line began to emerge. The story line is composed of what I consider are the most important revelations regarding the practices of exceptionally competent nurses I had made to this point. Like a story, it has an opening statement followed by supporting comments and linked as required to attain the format of a story. The content of the story line proposed is a result of the open and axial coding processes and the earlier hermeneutic analysis. The story line is as follows:

The main story seems to be about how nurses who were identified by their peers as exceptionally competent practitioners provide services to their patients. Some clues as to how these exceptional nurses are motivated to continue providing exceptional nursing care are also revealed.

These nurses have well-developed beliefs about the nature of nursing, the nursing milieu, human beings, health, life, death, and self which were conveyed through their narratives, comments, and actions.

Most significantly, they believe the patient is primary - their reason for being nurses, and the focus of their work. They respect individual differences. These nurses expect the nurse-patient relationship has the potential to be intimate; physical and emotional closeness are experienced by the care-giver and receiver.

Being cognizant of a sense of urgency in their work environment, the exceptional nurses are always aware that at any time they, or their patients, may become emotionally overwhelmed. They recognize that they work in a world of emotional extremes ranging from joy to despair.

Genuineness and honesty are key values underlying their behaviors. The nurses also value the opportunity for continued personal and professional development which they derive from their work. These beliefs and values influence how the nurses give care, and the nature of the care they provide.

Their care is focused on communicating to each patient their concern, respect for, and individual interest in them. Quality of life of the highest degree possible, as defined by the patient, is a goal they seek for each patient. This goal is what guides the nurses' decisions and actions.

Although they accomplish nursing procedures as other nurses do, these exceptional nurses share themselves with their patients as they provide this care, and they invite their patient to do the same. Through mutual touch, the dialogue of silence, and a focus on the lighter side of life, the exceptionally competent nurses become involved in the patient's experience and a connection is established. The way the nurses provide care affirms that the patient is valued. It communicates to them what they want and need most to know: that they are important, that they will be remembered, that there is hope, that there is meaning in their experience, and that they will be assisted to continue to live a quality life until they die.

By sharing themselves with their patients in touch, silence, and laughter, the nurses also benefit. Connecting with the patient affirms the value of the nurse as well. The exceptional nurses feel that they make a difference, that they are of worth, that their work is important. They find meaning in their experience. Like the patients, the nurses continue to grow and to learn through their nurse-patient encounters.

For both the patients and the nurses this inter-human contact and communication results in a connection and affirmation of value that leads to joint transcendence. Affirmation of value, connection, and transcendence may be the motivators that cause these nurses to carry on; they seem to be conditions needed for continuing to care exceptionally.

Moving from Description to Conceptualization

From the descriptive story, the central phenomenon has to be identified and given a name (Strauss & Corbin, 1990, p. 120). This becomes the core category, a category according to Strauss and Corbin that is abstract enough to encompass all that has been described in the story (p. 121). In this study the core category is joint transcendence.

Joint transcendence is broad enough to incorporate the others. It may be part of the basis of the qualities, values, and beliefs of the nurse; it may be a motivation for, and an effect of, the nursing actions and interactions. Joint transcendence may also be an effect of affirmation of value and connection.

Webster's dictionary defines transcendent as "exceeding usual limits, surpassing; extending or lying beyond the limits of ordinary experience; assertion of spiritual over the material" (1988, p. 1252). In exceptional nursing practice the nurse and patient, through their relationship, may both experience transcendence. As a result of their interactions they may evolve beyond what they believed possible. They may discover qualities in themselves that they had not known existed and be transformed in the process.

Determining the Properties and Dimensions of the Core Category

The properties and dimensions of the core category are discovered by relating other categories to the core category. Again a specific structure is used to facilitate this process. It is similar to the structure used in axial coding, only the statement of intervening conditions is omitted. The ordering is as follows: (A) causal conditions lead to (B) phenomenon, which leads to (C) context, which leads to (D) action strategies, which then leads to (E) consequences (Strauss & Corbin, 1990, pp. 124-125).

The researcher arranges and rearranges the categories in terms of the structure until they seem to fit the story and provide an analytic version of the story. In the words of Strauss and Corbin, "The story-telling and its sequential order are the keys to ordering the categories in a clear fashion. If the story is told accurately and logically, the ordering of categories should proceed easily" (1990, p. 129).

In this study the following interpretation of the structure seems to fit with the story line described: (A) causal conditions (qualities and values of the nurse), leads to (B) phenomenon (exceptionally competent nursing care), which leads to (C) context (the oncology environment/nursing milieu), which leads to (D) actions/interactions (mutual touch, dialogue of silence, sharing the lighter side of life), which leads to (E) consequences (connection, affirmation of value of the patient and nurse, and joint transcendence).

It is unlikely that the components of this structure follow one another in the linear fashion suggested. For example, the context probably has an influence on each of the other elements of this formula. It is doubtful that the context follows from the phenomenon as the model suggests. Likewise, the actions/interactions are part of the cause for the phenomenon as well as a result of it.

Although this model does provide a summary of the data in a concise form, it requires elaboration through description and inclusion of the nurses' stories and words. This description is provided in Chapter 9 with a focus on the consequences of the actions/interactions, (connection, affirmation of value, and joint transcendence) as these have not yet been analyzed or described hermeneutically.

Additional steps in selective coding can eventually, Strauss and Corbin claim, validate the relationships among the categories proposed. This validation is accomplished through the production and testing of hypothetical statements regarding these relationships. Further work can produce a conditional matrix, a framework that summarizes and integrates all of the data into a theory that is comprehensive enough to be generalizable. These final selective coding steps were no attempted as they went beyond the scope of this study.

CHAPTER SUMMARY

In this chapter, the grounded theory approach to analysis of the data was featured. It resulted in a second look from a new perspective at the study data. From this analysis new insights were made. Specifically, the categories of effects of nursing actions and interactions and the corresponding sub-categories of affirmation of value of the patient and nurse, connecting, and joint transcendence were developed. A story line that described the possible links between categories emerged, and joint transcendence was selected as the core variable.

This analysis both provided new categories for further discussion and echoed the earlier analysis in which the themes of dialogue of silence, mutual touch, and sharing the lighter side of life were identified.

I will turn now in Chapter 9 to a further elaboration and discussion through hermeneutic analysis of the new category of effects of nursing actions and interactions, the story line, and the core variable.

Chapter 9

A HERMENEUTIC ANALYSIS OF THE EFFECTS OF THE NURSING ACTIONS AND INTERACTIONS

CHAPTER INTRODUCTION

This chapter provides the final component of the multi-dimensional analysis designed to further understanding of exceptionally competent nursing practice. Subsequent analyses are left to the readers who may review the data provided and filter them through their own beliefs, biases, values, and experiences.

In this chapter I provide a hermeneutic phenomenological analysis of the grounded theory analysis in the preceding chapter. According to van Manen (1990) the aim of phenomenology is to transform lived experience into a textual expression of its essence. This is the goal for the analysis presented here. It is an attempt, in the words of Merleau-Ponty (1962), at "a linguistic description [of the effects of exceptionally competent oncology nursing practice] that is holistic and analytical, evocative and precise, unique and universal, powerful and sensitive." If this goal has been achieved, you will feel the description reawaken in you this lived experience, or at least you will experience the significance of the phenomena in a fuller or deeper manner (van Manen, 1990, p. 10).

The focus of this chapter is the theme identified in Chapter 8, that is, the effects of the nursing actions and interactions. Specifically, the sub-categories of connecting, affirming the value of the patient and nurse, and joint transcendence are described.

In keeping with the style of hermeneutic analysis established in Chapters 5, 6, and 7, this final synopsis relies heavily on the nurses' words and stories, and on a supplementary analysis through poetry.

CONNECTING

STEPPING INTO YOUR WORLD

There are moments when I feel like
I have stepped inside your world.
For just a flash,
I feel your pain,
I know your despair.

I sense what it's like to have cancer
from the inside looking out
at a world of people who are fit and well.

My God - it's so awful.
My God - it's so unfair.

Clayton, Murray, Horner, and Green (1991) define connecting as "the transpersonal experiences and feelings that lead to the sense of connection, attachment, or bonding between a nurse and a patient" (p. 155). The data reveal that this connection between nurse and patient is a complex and important part of the phenomenon of exceptional nursing practice. As described by the nurses, it involves several components: recognizing the similarities, seeing the former you, and participating in the patient's experience.

Recognizing the Similarities

Maureen told me this story about a connection that occurred very naturally with one patient. This connection developed partially out of mutual recognition of their similarities.

> Another patient, a young mother of two kids (notice I picked two women, close to my age, with children).... She had a brain tumor. This was a real warm relationship from the beginning. We shared - we were very close. I was overwhelmed sometimes by what she was going through. I remember how grateful I was for her that she had such a supportive husband. I was in awe of how much strength she possessed. Whenever you admire someone you want to be close to them and study them. She wrote me a poem that I got just after she died. She taught me a lot about me, and made a real difference in my life. I may forget her name but I will always remember her and the ways she was like me, and the ways I wanted to be like her.

YOU AND ME: THE SIMILARITIES

As different as cold and hot,
soft and hard,
happy and sad,
you and me.

Yet even where differences are vast,
there are similarities.

We do share...
a desire to be needed,
a desire to be loved,
a desire to be acknowledged,
a desire to be remembered.

Another nurse, Marie, told me this story of a patient with whom she connected though on the surface they seemed very different.

> She was sixteen years old. I'd been her nurse right from the very first admission day. We'd grown so very close. Unlike me, she was a wife, a mother, and now a very sick leukemic. Just too much for her 16 years to handle. To me she was just a young teenage girl in need of her mom.
>
> She returned from a pass one Sunday and eagerly searched me out to give me a photo of her 12 month old baby girl...Amy. I remember how proud she was as she showed

> me the photo and how carefully she wrote on the back and handed it to me. We both smiled and talked about her little one. I listened intently as a non-mother. This would be the last evening we would spend together in such a happy carefree way.
>
> Years later, after I had my own little girl, I was looking over an old desk calendar. Amy's photo slipped out and I recalled that evening. I now knew the joy of being a mom, the pride of having your own child and I realized that little Amy brought some beautiful rays of sunshine to a young teenage girl's last days.

IN ME, YOU

We recognize ourselves in others.

In you I see me,
my potential as a mother,
as a woman,
and as someone who will someday die.

The only difference between me and you
is that you are probably closer to your death.

This same nurse went on to tell me a story about connecting, finding a common bond, with a patient named Kenny. She said,

> I remember Kenny because he called the hospital from his home up north and said he was never coming back to the hospital in the city again. He was a typical teenager, rebelled all the time, didn't do the things he was asked to do, he was non-compliant through and through.
>
> After some coaxing he did come back to see us for a treatment. I was his nurse. The only thing he really liked was fishing and I thought, bingo, I can relate to fishing. I told him I liked to fish too and he said, "You like fishing?" with total disbelief in his voice. I said, "Yah, I can get into it." He tried some lingo on me about hooks and jigs and I passed. Then he said, "I've got something to show you." It was a home video of ice-fishing. The whole movie was of a hole in the ice. The odd time he would say, "Did you see that?" Then he would re-wind until we both saw the fish. That was our connection. On each visit I'd always start with, "How was the fishing?"
>
> There is always a connection possible. If it isn't going to be with me, maybe another nurse can do it for

that patient.

OVERLAPPING REALITIES

We are different?
We are the same?
We are essentially the same!

Finding that point where we are the same,
makes caring for each other so natural.

Seeing the Former You

The nurses described the ability to envision the patient in their minds as the person they were before they became ill as an important prerequisite to, and part of, connecting. Three of the exceptional nurses made these comments.

> When you see that stretcher coming down the hall with a new admission, the patient at first means very little to you. But as you get to know them, look at pictures of them before they were ill, see their personalities and features reflected in their family members, you feel a lot different about them.
>
> Your first contact with a new patient before you get to know them is hard. They are usually bald, jaundiced, thin,...not nice looking. And then you go into their room and start talking to them and all that disappears. You see that person as the person they were before. As you find out more about them you see the person inside, you see their spirit, their soul. I'm not sure what to call it...maybe their essence. The average person on the street would be repulsed by their appearance, but the people here who care so much see only their beautiful side.
>
> I always try to picture what the patient was like before they got cancer. I ask questions about what they liked and didn't like, about their hobbies, their work, their family interactions. Knowing these things just helps me give better care.

In a sense, "knowing" the pre-illness person facilitates establishing a nursing-patient connection. Maureen commented, "It's just easier somehow to connect with the patient if you have known them since their initial diagnosis or at least if you see pictures of them from before [they got sick]. Then you have the total picture of that patient." She went on to tell me this story.

> The patient in room 18 was a 16 year old girl with an astrocytoma. I knew she had been admitted many times before and had become a favorite of the staff, although I had never met her. I knocked on her door and entered the room. There in the bed lay a person, it was hard to know the age or even the sex of the body lying there staring at me with wide eyes. Her face was swollen, typical of the cushionoid syndrome that develops with prolonged steroid use. Her hair was sparse and patchy revealing her scalp. Her facial features drooped and her mouth sagged in one corner. Her body was swollen and her arm movements uncoordinated. There was evidence of anxiety in her eyes as she looked at my unfamiliar face.
>
> I approached her, gently laying my hand on her arm, and said, "My name's Maureen, I will be your nurse tonight." Some incoherent noises came from her mouth as she acknowledged what I was saying. She pointed towards a list with words on it, showing me her name, Maureen. I nodded and said, "I know, your name is Maureen too. You know Maureens are the best people. We should have a great time tonight." She grinned and pointed to a picture on her bed stand. The picture was of a beautiful young woman with long brown hair and a gorgeous smile. Maureen watched me, waiting for me to make the connection that this picture was of her.
>
> I looked at her and smiled. "Is this a picture of you?" I asked. Tears filled her eyes as she nodded. Then I realized how important it was to her that I knew who she was before she got sick, and that she was still that person. She taught me something that night that I will never forget.

When I asked Maureen about this story she elaborated on the lesson she received that night saying, "I learned that to provide the very best care I need to know who that person was before becoming sick and to realize that person and their history is very important to the patient I am now caring for."

Another nurse Moria gave me the same message when she said, "You have to see past the smells, cachexia, crumpled, broken, misshapen bodies to see the former radiance." One day on the unit when we were caring for a patient who was in such a state Moria said, "She must have been such a beautiful woman...just look at her skin and her hair."

INSIDE THE PEBBLE

Every pebble,
no matter how chipped and broken,
potentially contains
a dusting of gold.

Participating in the Patient's Experience

When I asked Mindy how she defined a "good day" she said, "I know I have had a good day when I make the connection with a patient, when I feel comfortable sitting on their bed or giving them a hug,...when I am part of their experience." Many of the nurses' stories describe times when they made this connection with their patients by participating in their experience through sharing their pain, suffering, joy, or an intimate moment with them. The following is one of Marie's examples of such an encounter:

> I want to tell you about one of my patients. He was a doctor himself: very ill, very uptight, very much in need of control over his care. I had known him only vaguely in his previous role as a doctor on the unit, and now here he was, my patient. I was called to perform a difficult procedure on him and I remember purposely thinking, how can I handle this, how can I make a connection with him?
>
> Before I brought in all of my materials for the procedure I went in and sat down with him. I told him my name and said, "You probably don't remember me, but

> I do remember when you were a doctor here." I said that I really remembered him and that he stood out in my mind because he was so personable and that I was impressed by how he had treated the nurses and his patients. I would have never been able to tell him these things except for the situation, at that moment he was in a more vulnerable position than I was. I just said what I felt, that I was really sorry that he had cancer.
>
> That time together was important. It made both of us feel at ease and I was able to do the procedure then without anxiety. When he came back for another treatment a week later he asked for me. I was glad I had taken the time to make that personal bond. He talked to me about his plans, the things he could never do that he wanted to do. Even after he knew that he was going on with his disease and he stopped the treatments he would always stop by and talk to me. I really miss him.

In this example, Marie participated in her patient's experience by spending time with him, sharing "secrets" with him, and giving of her self. All of these, according to Davies and Oberle (1990), are part of sustaining the nurse-patient connection (p. 90).

The same nurse went on to share this example of her participation in another patient's experience.

> She was young, sweet, soft-spoken. I just wanted to mother her. She had been through so much. She didn't really understand what disease she had, let alone that it was bad. We were like mother and daughter from the beginning. That was the nature of our relationship. With her I would just say, "You have to do this...," "Listen to me...," "Come on, you can do it...." I wouldn't use that approach with any other patients but with her it just really fit.
>
> I feel as if I shared in her experience. I was with her, at least in mind, from the moment she was admitted until her last day. She was my patient, I was her nurse. When she died so did a part of me.

THE CONNECTION

An unseen thread joins our spirits.

As we journey through this time together

we share ourselves with one another.
Things that would never be
appropriate to say to even my
closest friend,
are, with you, not only appropriate,
but necessary.

We both know that time is short.
To leave things unsaid now, is to
leave them unsaid forever.

AFFIRMING THE VALUE OF THE PATIENT

The connection between patient and nurse is related to affirming the value of the patient. An underlying focus of the care given by the exceptionally competent nurses is an acknowledgment of the patient as an important and worthy individual, as someone who has value. This is a part of the nurse's belief system as the two enter the nurse-patient relationship, it is reflected in the nursing care they give, and it is an effect of their nursing actions and interactions. Nurse researchers Davies and Oberle (1990) also identify affirmation of value as an important dimension of excellent nursing care. They write, "valuing, involves an attitude or mind-set that provides a contextual basis for all the nurse's activities" (p. 88).

From the data it appears that there are at least four major means by which nurses communicate to patients that they are valued, that they are worthy people. Specifically, nurses help the patient to be remembered; they help the patient to create meaning out of their experience; they treat the patients with respect and help them maintain dignity; and they help the patients see their possibilities, to find hope.

Helping the Patients Feel they Will be Remembered

REMEMBER ME

When I am gone,
I have only one request,
remember me.

Say my name,
and remember me.
Touch my things,
and remember me.
Recall my smile,
and remember me.

I simply have to be more than dust.
Dust is just dust,
and when the wind blows it scatters
and is forever
lost.

In an interview Julie said,

> People can take almost anything, but they can't take being forgotten. Anybody, if they have one wish, they want to be remembered. Every person wants to make some significant contribution. Sometimes it is part of my role to help them with this.

The same nurse wrote this story:

> A young mother of a three year old was facing her own death. She had brain mets that were interfering with her cognitive and motor ability to complete the many handicraft projects she wanted to finish and bequeath to her child. The disease was progressing quickly, she was overcome more and more with fatigue and confusion. She asked me to finish a counted cross-stitch picture for her, but instead we packaged up the partially finished picture, thread, and all with a note that said, "My dear, dear child...when you want to, please finish this picture and it will be something you can say we did together...my hand will guide you. Love, Mom."

Another nurse Jane said, "The patients, especially near the end, just want to be assured they will be remembered. No one can bear the thought that after they are gone, they will disappear and not matter anymore." I asked her how she responds to these concerns and she answered, "Usually I just help them believe that people will remember them. I say, `Let's talk about the people who will remember you,' and we talk about specific differences they have made in other people's lives."

Lana said, "Sometimes we have to be part of the group that remembers the patient." She talked about the responsibility she feels to remember certain people, especially those who may not have family members who will recall their memory. The nurses told me about gifts, poems, and letters they or the nursing unit had received "in memory" of specific patients. They felt it was part of their role to carry on these memories. Maureen in telling me about a patient who had written her a poem that she had received just after the patient died said, "I may forget her name, but I will always remember her. It is just part of what I do."

Jane commented, "A part of remembering is recognizing the uniqueness of individuals, because in remembering we recall what made that person special. There isn't a patient that isn't special in some way."

Helping the Patients Find Meaning in Their Experience

In an interview Marie stated, "Probably the hardest question I am asked is, `Why me?', and all the patients ask it in their own way, in their own time. What can I say? It's really, really hard." What she was addressing is the role the nurses play in helping their patients create meaning out of their cancer experience.

Frankl (1969) writes about the importance of finding meaning in our experiences. He says,

> To live is to suffer, to survive is to finding meaning in suffering. If there is a purpose in life at all, there must be a purpose in suffering and dying.... If one succeeds, one will continue to grow in spite of all indignities. He who has a why to live can bear with almost any how.

It seems from the examples provided by the exceptionally competent nurses they work together with their patients to help them find their whys. Oberle and Davies (1992) also acknowledge that expert nurses work at helping patients find meaning, or more precisely, they help their patients make sense out of what is happening to them.

In a similar vein Burke (1985) writes, "Each person strives to create meaning out of his existence in the world and attempts to gain freedom from crippling fear, anxiety, and guilt" (p. 95).

Some nurses suggested that when confronted with the possibility of death, the urgency of this search is accelerated. Simultaneously, due to the devastating nature of the disease, this quest becomes more difficult. As Lana said, "How can a person be expected to find meaning in suffering and death? How much more difficult can it get?"

Although the nurses acknowledge that it is a difficult task, they recognize their role in helping the patients with their search for meaning within the limits of their individual circumstances. Julie told me this story of a man she helped to find meaning in a life that had been devastated by more than cancer.

He was a tall, good looking man. At his request, there was a "No Visitors" sign on his door. He drew pictures, he discussed world politics. He didn't cry... he didn't laugh; he watched. He gave single word answers. His patient history report said he was an atheist. He had attempted suicide because he did not wish to put his wife through the excruciating process of slowly watching him die. He was admitted to prevent any subsequent suicide attempts.

I personally believe that, given enough opportunities, even the hardest rock can be, if not cracked, at least warmed by the sun. Initially, that rock was all I saw, but this man taught me about the "sands of time" and the importance of approaching every situation with caring and honesty, and to never judge.

I am good at making people feel comfortable. I enjoy helping them get rid of a lot of emotional garbage. I knew he needed to have his inner fears affirmed, to come to terms with the grief and the multitude of losses he was encountering. He needed at least to search for answers to the question, "Why?" I recognized his loneliness and his fear. How was I going to let him know I was there to help?

The opportunity finally arrived one evening. He all of a sudden said, "Do you believe in God?" I answered carefully, not wanting to shut the doors. I said, "I really don't know about God per se. But I do believe in angels."

Regardless of my attempt, his part of the conversation quickly changed to the practical matters at hand, like the size of his pyjamas. However, with the passing weeks, we did discuss angels, a little bit about God, grief, anger, hate, and how unfair this was.

He told me a lot about his life. He had been a young family man during the war, an army officer. One day he and his wife went for groceries leaving their two boys at home. While they were gone, their home was bombed. Their home and family were destroyed. As postwar refugees to Canada his wife bore another son who died shortly after birth. In an attempt to gather some semblance of normality after all this heartache, they adopted an infant. This child was now in his mid 30's and mentally handicapped.

I think of him often. I was fortunate to be with him in his last moments. I held his hand. All I could do was

> stand there and hope that he was seeing his kids. I prayed, "Please if there is a God, this man deserves to see his kids."
>
> I don't know if it was just the effects of his drugs or what but when I said to him as he was dying, "Your sons are there," he squeezed my hand. He really did. He squeezed my hand and died. And I sobbed.

FINDING MEANING: THE FIRST STEP

You listened to me with openness.

Into your willing heart I poured
my fears, my sadness, my guilt.

Now that I am free of these chains
there is a chance I may find serenity.

Just by listening to this patient and helping him to relive his stories, Julie set him on the way to being able to find meaning in his experience. Without this opportunity to free oneself of the guilt, and pain of past failures and sorrows, it would be difficult for any patient to think clearly about what part the cancer experience plays in their life. As Levine (1987) said, "When the mind is clear, we can see all the way to the heart" (p. 66) and "when the heart is exposed there are no obstacles in the mind" (p. 77).

Once the "emotional baggage" has been addressed, the nurses talked about the important role of a spiritual element in helping their patients create meaning. As Jane said, "Even if you have never really believed in God or some higher power, it crosses your mind when you face your own, or someone else's mortality."

Most of the nurses described their own well-developed spiritual beliefs as documented in Chapter 3. Having faith in the existence and mercy of a higher being was important in their ability to help patients create meaning. For example, Julie told me,

> If a patient is really struggling with the "Why me?", and "What will happen to me?" questions and they have no faith of their own, I let them cling on to mine until they can find their own. Some of them never do, but I am glad I can help them in this way. I couldn't if I wasn't sure myself, if I hadn't already found my own way.

Marie said that the patients often found meaning in their disease by first considering it part of their destiny, "God's plan for them." As Lana commented, "Once they accept it, they can start to see the glimmer of good in the devastation around their worlds." Another nurse Jane said, "Acceptance of their situation lets them get back control so they can make sense of the chaos and disruption the illness can cause."

THE POSSIBLE GOOD

Cancer is like a piece of sand
inside an oyster.

If you accept it is there,
and see purpose in its presence,
it can create a pearl.

Otherwise,
it just irritates and scars.

Treating Patients with Respect and Helping Them Maintain Dignity

Treating their patients with respect and helping them maintain dignity was another way these exceptional nurses showed their patients they were valued. The respect that these nurses have for their patients, as reflected in their statement of beliefs about the nurse patient-relationship, prompted their concern for maintenance of patient dignity. In many of the stories told, this concern underlay the nurses' choices and actions. Frequently, the nurses were patient advocates in an attempt to provide the patients with quality of life as they defined it. As the following story illustrates, doing so can facilitate the sustenance of patient dignity, and the value of the patient.

> He was only nineteen years old, far, far away from home and desperately in need of a bone marrow transplant. His home was in a small Native community in Northern Canada. He was Native, and this was his first trip outside the area in which he lived. Naturally, I expected that my task would be to support him and prepare him for his trip to Toronto for his transplant. But the more time I spent with Ralph, the more I realized he did not share those plans and hopes. Ralph always amazed me because he was insightful, spiritual, and truly at peace with his situation. He was also very alone, frightened and intimidated by the hospital surroundings. A bone marrow transplant would mean more loneliness and a greater separation from his family and home. A transplant at this stage of his lengthy illness provided only limited hope for a prolongation of life.
>
> Ralph confided in me that his only desire was to return home to be with his family, to experience a familiar sunset before he died. I knew in my heart this could be the only choice for him...Ralph was an inspiration to me. His decision was not popular with his physician who was disturbed by his "giving up," but Ralph never gave up on his decision.
>
> I, along with my colleagues, were resolved that going home was the only correct plan for Ralph. We presented Ralph's position to the doctors, and defended it adamantly. The bone marrow transplant was cancelled.
>
> Ralph never did return home, but died in room 72 surrounded by his mother, brothers, and sisters. He was at peace, and so was I. I truly missed him for sometime after. The medical goals of cure and treatment may often be less important when we can clearly distinguish between quality and quantity of life.

RESPECT AND DIGNITY: THE LINK

Your body,
your right
to decide
its future.

My role,
respect that right
and help you
maintain your dignity.

Patient dignity was also maintained through nursing actions that helped the patients to know that they were still important, that their lives still mattered. The following is an excerpt from a letter I wrote to one of the exceptional nurses documenting my observation of her in such a situation.

> Dear Moria:
>
> Today I watched in reverence as you cared for your patient. So gently you removed the mountain of bandages that covered what once was his back and buttocks. You respected his privacy by placing a tiny towel over his chest, the only part of his body that didn't need to be exposed during the procedure. I was moved by this symbolic gesture. You respected him, he was more than a patient to you, he was someone you cared about. The smells when you removed the dressings were so bad. I wanted to turn away, but you showed no sign that it bothered you at all. In fact, you moved closer, carrying on a cheerful conversation with him about his life, his work, his grand-children. In doing these things you maintained the dignity of a man who probably had only a thread of it left.

PRIVACY IN A VERY PUBLIC SPACE

Masterful creation
of the illusion of privacy
does wonders to protect the
last remaining grains
of pride and self-respect.

Often times it is just the respectful ways that the nurses carried out their nursing tasks that communicated to the patients that they were important. The following field notes documented some of the little things that the nurses did for the patients that I believe helped the patients to feel valued.

> She takes an infinite amount of time with each patient. Mrs. Long asked to have her legs elevated. Moria makes minute adjustments to her leg positions until the patient indicates that the angle and the supporting pillows are perfectly positioned. Even after the sign of approval by the patient, Moria waits to make sure everything is satisfactory.
>
> The attention to detail is remarkable. Warming the towels in the drier so they are cozy after a bath, warming the lotion in the microwave, warming the milk at bed time...all of these take time, but the actions seem to help the patients feel important, valued, more worthy. No request is too much for these nurses. In fact, the patients seldom need to ask. The nurses anticipate needs the patients don't even know they have.
>
> The patient is ringing her bell every few minutes. When the nurse I am watching answers her call, the patient's complaint is that she can't find her bell. Later she rings again to tell the nurse she doesn't want to be disturbed. Each time the nurse answers the summons with sincere interest and pleasant patience.

Peter said to me, "Helping patients to feel important can be as simple as knocking on their doors before entering their rooms or asking them what time they would like their baths." Another nurse Marie concluded,

> Making the patient feel like they are the most important person in the world, even if it is just for the moments you are with them, that should be our goal...that has been my goal. Patients are the priority. It's the little things that make a patient feel important, like the way you enter a room. I consciously slow down my pace as I enter. I take time to sit down in the patient's room and really listen to their concerns. I attend to their needs in short order, not waiting to be reminded. If possible I anticipate their needs before they ask like offering them an extra pillow or dealing with a red skin area. You just let them know that they still matter. Even if it is just for this moment, you

matter.

The nurses I observed continued to show respect and maintain the dignity of their patients even after they were deceased. In a field note I wrote,

> As we enter the dead woman's room, the nurse dims the lights, and tip-toes across the floor to draw the curtains. She talks softly to the woman as she prepares her body for the morgue. In a very quiet voice, she bids the woman, her patient, good-bye.

The importance of showing respect and maintaining patient dignity is supported by Benner. She writes, "Almost no intervention will work if the nurse-patient relationship is not based on respect" (1984, p. 209).

Helping the Patients Find and Maintain Hope

By helping the patients find and maintain hope, the nurses caused the patients to feel they still mattered. The following untitled, anonymous poem posted on the wall of the nursing unit where this study took place, is a concrete symbol of the importance of maintaining hope.

Cancer is so limited....
It cannot cripple love,
corrode faith,
eat away peace,
destroy confidence,
kill friendship,
shut out memories,
silence courage,
invade the soul,
quench the spirit.
The greatest enemy is not the disease,
but despair.

After reading this poem Jane said, "If the patients see no hope, no possibilities for even their immediate future, they are left with despair. But it is part of my goal to help them see possibilities, and set goals that are attainable."

Another nurse Julie described some of the ways she helps patients realize and accept their limited potential without taking away their hope. She said,

> First, you have to honest with patients. People can take a yes or a no very easily as long as you are being straight with them. When someone is lying there dying, nauseated, and in pain, the last thing they want to hear is, "It's going to be O.K." At that moment it is not going to be O.K., and that moment is a year long. Cut the crap.
>
> If they say "Am I dying?", you say, "Yes you are dying." They are so content with that because someone is telling them the truth. You say to them, "I'm not going to lie to you." Lying to patients destroys their hope. It lets them down. If you lie to them and tell them they will be able to do something and then they can't, they won't chance hoping again.
>
> If they say to you, "Will I be able to walk?" and they won't, say, "No...but let's try sitting up in a chair." If they ask you, "Can I go home again?" and they can't, say, "Probably not but let's try a pass for two hours or maybe you can just get out of your room." Just give them something. We don't have the right to destroy their hope. I never promise my patients something I can't deliver.

THE POSSIBILITIES

Your body has been cruel to you,
harnessing you,
limiting your possibilities.

I am here to free your shackles
and set your spirit soaring,
just by helping you see your choices.

Hope is a belief that something good lies ahead. It is not denying reality. Realistic hope can help the dying person face reality, while it also gives them strength to go on living. Jane said, "I think giving patients hope is important. I used to think that being cheerful was a way of giving hope, but now I know it is helping them find courage."

INFECTIOUS HOPE

Hope.

It cannot be taught,
or bought,

but can it be caught?

In this story Maureen described how she used her nursing skills to help her patient maintain hope.

> This patient was in a lot of pain. We had given her break-through medication but it didn't work and she was crying out. The nurse who was assigned to her was upset and didn't know what to do. She asked me for help so I went into the room and calmly said, "We are going to try something different." I didn't have a plan when I walked in or even when I said we were going to try something different, I just knew we had to give her some hope.
>
> First, I tried visualization...a Hawaiian beach...that didn't work. So I went into muscle relaxation and sure enough it worked, probably because the analgesic had kicked in by then too. But the distractions of trying these alternatives kept her mind off her pain and let her know we were not going to give up on controlling her pain.

HOPE IS TO LIFE

Hope.

Without it what is life?

Bleak,
onerous,
hopeless?

Hope.

With it what is life?

Lively,
promising,
hope-filled?

In commenting about hope Lana said,

> It is probably the greatest need our patients have. Those without hope just give up and lead a poor quality of life. Those with hope, have power over their disease and live a good life until they die. The only problem is, hope is difficult or maybe impossible to dispense because it is a quality of the spirit.

One of my field notes reads,

> It seems strange to write about death and hope in the same sentence, but where would the dying be without hope? Those who can't find it collapse inwardly and die before they are dead. Those who somehow discover or choose hope have the elusive quality of life the nurses I'm watching desire for their patients.

On the importance of hope for the dying patient McHutchion (1987) writes,

> The hope for the miracle of cure becomes hope for a miracle of care. Patients and families believe that when pain and symptoms of the disease and side-effects from treatments and medications are controlled, the patient and family care-giver are freed to live toward a good death. (p. 320)

In another journal entry I recorded an encounter where a dying man was helped to find the strength to continue hoping for the miracle of care.

> A physician approached the nurse I was watching and asked her to come to take a look at Mr. Bill Selsby. Entering the room, we find a man lying in bed, silent, and staring at the wall, his eyes fixed. The doctor concludes that the patient is close to death, and that the diagnostic test scheduled for Mr. Selsby that day should be cancelled.
>
> After the physician leaves, the nurse does her own assessment of the patient. She goes close to him and studies him very intensely. Placing her hand on his forehead she says, "Bill are you sad? Are you sad because today is your birthday?" She stays in this pose for a few minutes, waiting for a response, a signal, a clue from the patient. I see nothing. She sees what she needs to see.
>
> Leaving the room, the nurse walks up to the doctor and says, "I think you are wrong about Mr. Selsby...his

eyes are reacting. He is not dying, he is just down and depressed."

During the day as we visit Bill's room he becomes more and more responsive. The nurse talks to him about his life, asking him questions about his children and his birthday wishes. At first he doesn't say much, but eventually he begins to talk.

Just before change of shift, the nurse gathers her colleagues together to help her surprise Bill with a cake. Together they sing the most rousing and sincere happy birthday song I have ever heard. The man who was supposedly taking his last breath cuts the cake, and eats a piece with his tea which the nurse had carefully steeped to his liking and served to him in a china cup.

In a final demonstration of caring, she places a birthday kiss on Bill's forehead, setting an example for the other nurses who follow her lead. As we leave the room and bid Bill a happy evening, I see the sparkle of life that has returned to those eyes. Bill has hope.

HAPPY BIRTHDAY

"Happy birthday to you.
Happy birthday to you."

You sing with enthusiasm.
You sing with warmth.
You sing in unison.

In the lines
between your words
you sing this message...
Bill, you may not have many
more birthdays,
but let's just celebrate
this incredibly important birthday moment,
and the hope that it brings.

AFFIRMING THE VALUE OF THE NURSE

As the patient is affirmed by the nurse's actions and their interactions, the nurse is also affirmed. From the observations and the comments of the nurses, this seems to happen in two major ways. First, the nurses come to know that they are making a difference in the lives of their patients or their patients' families. Second, like the patients, the nurses also find meaning in their experiences.

Making a Difference

Maltz (1970) suggests that human beings need to feel they are important. One way that they do this, Maltz proposes, is by helping or adding happiness to other human beings. The nurses in the study often commented that they found their work rewarding, in part because through their work they were able to do as Maltz (1970) suggests. When asked to elaborate on their feelings about their work participating nurses made the following comments:

> A lot of nursing is doing for others. When I do something for my patient and it is successful, I feel valued. Like what I do is constructive, and I am worthy. It's a great feeling.
>
> I just know that almost every day when I come to work I am going to change somebody's life. It's an awesome power. I take it really seriously. These people with cancer, they are so vulnerable, so needy. I am privileged to be part of their lives at this time when they need me so much. I always feel needed by my patients...and when I can meet their needs it really makes me happy.
>
> The most rewarding for me is taking a patient from a situation where they are in a lot of distress, or confused and cognitively impaired, and doing a few simple measures that help them to be alert so they can talk to their families and be comfortable...it is so satisfying to give them some quality back to their lives.
>
> The rewards are the little things, seeing individuals come back when they have been through a long journey and seeing them triumph. It's a real joy to share that with them. Even if the patient has died, to have the family members come to you and greet you like you were a real special part of their lives is a great feeling. I think of few careers where you can interact with people so closely and feel so helpful to someone, and feel I really make a difference. It is important to me that

what I do is worthwhile.

TO BE VALUED

I am so alone,
my companions likewise.

But, if I can be vital to but one other,
even for a moment,
I increase my own happiness
by at least one hundred fold.

Maureen told me a story about making a difference in a family's life. She said,

> This is a story about a young couple. He was diagnosed with colon cancer and he was only 32 years old. He had two children and so did I. He was really withdrawn all the time and the only thing that could get to him was humor, so I used to joke with him and that would get him talking a little. He was in excruciating pain, but he didn't stop doing the things he loved like driving his tractor.... His wife and I really hit it off, we had a lot in common. She would call me about his pain and other things. One day she called. He was really in trouble so we asked her to bring him to the hospital.
>
> When he got here I could see he was near death. He was confused, dehydrated, atrophied. I took his wife aside and talked with her. I told her exactly what I was seeing.... I said that I noticed a big change in him since the last time I saw him.... I didn't have to tell her that he was dying, she already knew. She told me that it was important to him to die at home so I set about arranging things, medications, home-care, all the things they needed to make it possible and we sent them home. He died the next day.
>
> It was an extraordinary time for me because I really felt like I made a difference in their lives. They were important to me, not because they taught me a whole lot but because they made a difference in my life too.

Julie wrote a story about feeling like she made a difference in a patient's life with a very small but authentic gesture of caring.

> There's the time I was "out for coffee" (I don't even drink coffee) with the wife of a former patient. Meeting me again was difficult for her as I represented a very sad time in her life. I had shared the approach

> to and death of her husband. They had obviously shared a special, loving relationship. She wanted to talk with me again, but it was not without a flood of memories. While we drank our coffee she described to me a moment that the three of us had shared, to which she had often returned during her bereavement. This is the moment.
>
> One time on my perpetual medication rounds I entered her husband's room. I found her and her husband both asleep. He was lying on his bed. She had her head on his chest and he had his fingers interlaced in her hair. It was a peaceful and loving sight. I could not interrupt, so I simply wrote them a note on the first scrap of paper I could find, a little yellow sticky. The note said, "Was here, please call when you're awake. You looked so peaceful, just couldn't interrupt. Your Med. Nurse."
>
> Much to my surprise she had kept the note. She pulled it from her purse that day. It was dog-eared and tattered but she still had it! Her husband had a huge funeral. There were probably hundreds of Hallmark cards. It had been more than a year ago. She had travelled, she was doing well, but she had saved this little seemingly insignificant yellow sticky note. A reminder to me that yes, we all may secretly wish for fame and fortune, the big things are so obvious, but it's the little things that really do make a difference. My little thing had made a big difference to her. I felt so good.

When I asked about the most satisfying aspect of her job Marie told me this story.

> Last week a patient's wife came in and wanted to talk to me about her husband's passing. Weeks earlier, when I was his nurse I felt like I was one of her family, and it was a really rewarding time though there were a lot of difficult moments. Now, after his death, she was reaching out to me again. There were many people she could have chosen to reach out to, including family members, but she chose me.

The display of thank-you cards on the nursing unit is another concrete acknowledgement of the difference the nurses make in patients' lives. During visits to their homes, some of the nurses showed me personal cards, tokens, letters, and poems they had received from their patients.

These were prized symbols of the difference they had made in the lives of others, stored over the years, kept with a sense of sacredness. The following are excerpts from these messages sent to the exceptionally competent nurses.

> My grand-mother's life ended with dignity and self-respect. By giving this gift to her, not only was her death respectable, but her life (to the end) was surrounded with love.
>
> What comfort and peace you brought to my Mother. I will never forget you.
>
> Once in a while you meet someone who is really special. You are my special angel.
>
> As I think back over all that we have been through together, I realize that I couldn't have done it without you. I am eternally grateful.

THE MIRACLE CIRCLE

Sometimes,
when I think about
the vastness and complexity of the world,
I am overwhelmed.
I feel so unimportant,
so insignificant.

Then,
I meet you,
and with a small gesture, lovingly given,
I make you feel valued.

The result is a miracle...
when you feel important,
so do I.

It's so simple.
It's so profound.

Finding Meaning in the Experience

As the nurses found meaning in their own experiences with caring for cancer patients, they came to feel valued. Like the patients, the nurses struggled to find this meaning. Making a positive difference in the lives of their patients and the patients' families is one of the ways the nurses found meaning. However, they did tell me of other ways this meaning was realized.

As discussed in Chapter 3, the exceptional nurses value continued personal and professional learning. They seek challenges that facilitate this goal and their work provides these challenges. For many of the nurses having this opportunity for ongoing enhancement was a part of finding meaning in their work. As Jane said, "Everyday I learn something new about cancer, or about caring, or about me." This finding was reflected in other comments.

> When I first started here I planned to stay maybe a year, but now it is two years later and I am still here. When I ask myself why, I realize it is because I still have a lot to learn here.
>
> I just can't imagine a job where you know it all...where you could do everything perfectly all the time. This work is so demanding, so challenging, so dynamic that knowing it all would never happen. That's good. That's the way I like it. That's why I stay.
>
> I really enjoy the opportunity to continue to learn. I go to cancer conferences and come back inspired, proud of what I do, and full of new ideas. I read journals and I'm happy to have the chance to try out the new ideas with my patients.
>
> We can still keep on learning. Even if you have learned the lesson once, you still have to be reminded from time to time. That's the beauty of this job. You never, never stop [learning].

CHALLENGE SEEKERS

You only become greater
if you are first confronted with
not knowing how.

In your wisdom you recognize this,
and seek
and welcome

the obstacle of challenge.

The exceptional nurses recognized that they were not perfect nurses or perfect people; that they were not finished their journeys. They suggested that they did not ever expect that they would achieve perfection, although they enjoyed working toward that unattainable possibility. The result was a yearning for continued learning and growth. In a letter to one of the nurses, Peter, I wrote,

> I am impressed with your interest in continuing to learn, developing your nursing abilities along with your personal qualities and philosophies. One important point that you helped me to bring to light is that exceptionally competent nurses are not perfect. I think most people equate exceptional with infallible, but that isn't true for any of the nurses I observed. What is true is that exceptional nurses are self-aware, they know their own limitations and their strengths and they adjust their practice accordingly. In addition, they have a desire for life-long learning. I believe this may demonstrate a level of maturity that only rare people reach.

Beyond seeking and overcoming challenges, there were other ways that the nurses studied found meaning in their experience. For example, Jane described how helping the patients create meaning from their experiences actually helped her create meaning from her experience. She said,

> Working here I have come to grips with a lot of the heavy issues, you know life, death, religion, love, family. You have to help the patients with these issues first, but when you do, you can't help also working through the same issues in your own life. It just happens sort of naturally.

As we discussed it further she began to debate in her mind which comes first. She said,

> I'm not sure if you deal with you own issues first to prepare you to help your patients, or if being confronted with their issues forces you to quickly

> determine what life is all about. Maybe you go back and forth, you do a little work on your own and then you help your patients and then it's back to you. Yes, I think that's it...I work on it with the patients. Confronting their issues with them forces me to face my own circumstances.

In addition, many of the nurses suggested that they found it necessary to find meaning in their lives outside of work, in order to find meaning in their work. Again this was a simultaneous process, working on discovering meaning in all parts of their lives at the same time. However, the agreement was that they found the searches mutually supportive.

FOG LIFTED

What a vague idea,
the search for meaning.
Yet, once found,
it becomes crystal clear.

JOINT TRANSCENDENCE

In writing about transcendence O'Banion and O'Connell (1970) suggest, "Transcendence changes things, the past, the present, and the future. Once transcendence occurs there is no retreating. It is more than the ordinary" (p. 160). Watson (1989) is more specific in her description of transcendence, placing her discussion within the context of the nurse-patient relationship. She says,

> When both care provider and care receiver are co-participants in caring; the release can potentiate self-healing and harmony in both. The release can allow the one who is cared for to be the one who cares, through the reflection of the human condition that in turn nourishes the humaness of the care provider. In such connectedness they are both capable of transcending self, time, and space. Neither stands above the other. (p. 132)

In an earlier work, Watson (1985) writes about "transpersonal caring," a situation in which "both the nurse and patient are changed by the actual caring event" (p. 58). She describes this situation as having a "field of its own that is greater than the occasion itself and which allows for the presence of the geist or spirit of both" (p. 58). To expand further, Watson (1985) suggests that when both the patient and the nurse are fully present in the moment there is a feeling of union with the other. In her words, "the event expands the limits of openness and has the ability to expand human capacities" (Watson, 1985, p. 59).

In some ways all of the narratives and observations described in this dissertation illustrate a part of this effect of exceptional nursing practice I have called joint transcendence, or what Watson (1985) describes as transpersonal caring. Yet, no one story or moment observed illustrates it completely. O'Banion and O'Connell (1970) describe the difficulty encountered when one attempts to write about transcendence. They conclude that transcendence "is an experience so far beyond the ordinary...how can we speak of it in everyday words? Of course we cannot" (p. 160).

In following their advice I have decided to use few words to describe this final category. Instead the poem, Shared Journey, attempts to distill from the collection of data what is meant by joint transcendence.

SHARED JOURNEY

Together,
nurse and patient
rise above the pain,
suffering,
and despair
of cancer,
and climb to the top of the mountain that
has no summit.

They take turns
carrying one another.
For they know that neither
can make it alone.

In their time together,
they share through touch,
silence,
and light-heartedness.

In their time together,
they learn about themselves,
their needs,
their strengths,
their limitations.
But most important of all
they learn about their similarities.

They both share the common fate
of mortality,
an understanding which makes
the pleasures of life more intense.

They both possess the potential
for knowing joy,
awe,
and wonder.

They both can understand
that though the physical body
may be diseased,
disfigured,
distasteful,
the spiritual body can be healthy,
beautiful,
and whole.

Through the intimacy of their
relationship they discover
they are valued,
they are worthwhile,
that they can,

and do,
make a difference.
Each, in their own way,
creates meaning out of their experience.

As they reach
higher and higher planes
the patient may leave
to take up challenges elsewhere,
while the nurse,
having gained strength
from the journey
is able to carry on.

CHAPTER SUMMARY

This chapter featured a hermeneutic phenomenological analysis of the theme of effects of exceptionally competent nursing actions and interactions. Specifically, three subcategories of connecting, affirming the value of the patient and nurse, and joint transcendence were described using the participating nurses' words and field notes detailing their actions and interactions.

Connecting was seen to occur when the nurse and patient recognized their similarities, when the nurse came to "know" the pre-illness patient, and when the nurse participated in the patient's experience.

The nursing actions of touch, silence, and lightheartedness helped to make both the nurse and patient feel important and valued. The nurses wanted to assure their patients that no matter how physically unwell they were, they were still important people. Helping the patients feel they would be remembered, helping the patients find meaning in their experience, treating the patients with respect and helping them maintain dignity, and helping the patients find hope were ways nurses assisted patients to feel valued.

The nurses too came to believe that they were making an important contribution, that they were valued. Feeling that they made a difference in the lives of their patients, and finding meaning in their own experience with cancer care-giving were two ways that the nurses came to this understanding.

Finally, the effect of joint transcendence was described. This is a state experienced by the nurses as they shared with their patients through touch, silence, and light-heartedness, as they connected with their patients, as they helped them to feel valued, and as they came to realize their own value.

REFLECTIONS ON THE EFFECTS OF EXCEPTIONALLY COMPETENT NURSING ACTIONS AND INTERACTIONS

While categorizing the data into themes and sub-categories was probably necessary in order to make some sense out of what otherwise was a large collection of transcripts and journal entries, it still seems in many ways limited to me. Many of the narratives could have been used as effective illustrations for more than the one theme they were assigned to. Each story in some ways described both nursing actions and the effects of those actions, yet, I have defined separate effects sub-categories and selected certain stories as illustrations of these specific effects.

This complexity became especially evident when I attempted to select the data that described the effect of joint transcendence. As I mentioned earlier, all of the data are in some ways descriptive of this phenomenon, yet, taken in isolation, no one narrative or observation can describe it completely.

In addition, the words we have available in our written language are limited when attempting to describe something that contains elements of the physical, emotional, intellectual, and spiritual; the verbal and non-verbal. For this reason it is difficult to capture and communicate the full nature of exceptionally competent nursing practice in a few written pages.

Exceptionally competent nursing practice is simply not as linear as it appears when it is analyzed and packaged in a dissertation. For example, in some ways the dialogue of silence, mutual touch, and sharing the lighter side of life do facilitate connection, affirmation of value, and transcendence, yet, as connection, affirmation of value and transcendence become stronger the use of silence, touch, and light-heartedness also evolve. From this study one cannot conclude that the actions necessarily lead to that which has been labelled the effects because the effects also seem to have an influence on the actions.

To complicate this further, the connection, affirmation of value, and joint transcendence a nurse experiences with a certain patient prepares that nurse to initiate silence, touch, and light-heartedness, possibly in an enhanced way, with another patient.

It is also important to consider the part that the nursing philosophies articulated by the exceptionally competent nurses, and described in Chapter 4, play in these interactions. In some ways the nurses' beliefs about the nurse-patient relationship, nursing, health, the nursing milieu, human-beings, self, and life and death may give rise to certain actions and effects. Yet, their nursing philosophies are not static, they continue to evolve as the nurses have new experiences and reflect on various patient encounters.

Despite the confusing intricacy of exceptional nursing practice and the complex means by which the nurses' philosophies, the actions and interactions, and effects of these all seem to intertwine, I still believe that through these exceptional nurse-patient associations something remarkable occurs for the nurse and probably also for the patient. This extraordinary happening I believe is joint transcendence. Again, I turn to poetry to illustrate the power and potential of such encounters.

I AM YOUR NURSE

I am your nurse.
I ease your pain.
I bathe your skin.
I make your bed.
I rub your back.
I meet your needs.
You heal me.

I am your nurse.
I feed you meals.
I give you rest.

I tend your wounds.
I sense your suffering.
I answer your questions.
You teach me.

I am your nurse.
I know your pain.
I know your loneliness.
I know your despair.
I know your joy.
I share your spirit.
You touch my soul.

And sometimes,
for just a moment,
I am you,
and you are me,
and we are one.

Together,
we go beyond the limits
of ordinary experience,
to live the extraordinary.

Chapter 10

CONCLUDING INSIGHTS AND QUESTIONS FOR FURTHER INVESTIGATION

CHAPTER INTRODUCTION

After removing myself from the writing and re-writing process for several weeks, I discovered broader insights that provide both a summary for this dissertation and a reservoir of further research questions. These insights and questions which represent a re-focusing of my thinking away from the more detailed analysis to a wide-angle view of the practice of exceptionally competent nurses are featured in this chapter. Also addressed in this chapter are the claims for significance of this study originally proposed in Chapter 1.

The chapter is organized in the following way. First, the purpose of this study and the methods used are reviewed. Second, the reader is reminded of the approaches to data analysis employed. Third, the broader insights mentioned above are described. The insights are divided into two groups, those that have potential significance for nurses and insights of possible interest to other human services providers. Consistent with the style of this dissertation every insight features a poem or an excerpt from one of the exceptional nurses' comments or narratives. Fourth, as appropriate, each insight is followed by a discussion of its meaning for practitioners, educators, researchers, and administrators. Fifth, related ideas for further investigation are presented. Finally, a summary statement and description of the effect of this study on the researcher concludes this chapter.

PURPOSE AND METHODS OF THE STUDY: A RECAP

The purpose of this study was to explore the beliefs, actions and interactions, and effects of the actions and interactions of exceptionally competent oncology nurses. This investigation centered on the broad question: What is the nature of exceptionally competent nursing practice?

The eight study participants were chosen by peer nomination. Data were gathered through observation, conversation, and narrative exchange.

COMPONENTS OF THE ANALYSIS: A REVIEW

To come to the understandings presented in this dissertation the data were analyzed in several ways. The initial analysis was done by the study participants. This was provided voluntarily by the nurses as they shared their narrative accounts and conversed with me.

A weaving together of the nurses' narratives and comments with fields notes and quotations from related literature provided additional perspectives. These elements were arranged in themes. The integration of the literature into the description of the themes provided an exploration consistent with a hermeneutic phenomenological approach.

Poetic interpretations were also incorporated into the hermeneutic analysis. Hopefully, these poems provide both a summary of veiled meanings contained in the narratives, comments, and observations and a further analysis. In some ways poems expose the tacit and communicate the emotion of the situation described, leaving the reader with a greater understanding of the experience.

A further understanding of exceptionally competent nursing practice was sought through grounded theory analysis (Strauss & Corbin, 1990). During this process the data were reviewed again. This time the search was for additional themes and a core variable.

The final analysis is left to the readers, to form their own insights regarding exceptional nursing practice. Much of the data was presented in verbatim form to facilitate this personal analysis.

In summary, two qualitative methodologies, grounded theory and hermeneutic phenomenology were combined in this study to provide an increased illumination of exceptionally competent nursing practice. Each offered a unique and complementary contribution. Hermeneutic phenomenology provided the rich detail that conveys the context and humanness of the experience of exceptionally competent nursing practice, while grounded theory provided analysis at a more conceptual level. I believe that the result is a more complete picture of exceptionally competent nursing practice than could have been accomplished by any single approach.

INSIGHTS OF POTENTIAL SIGNIFICANCE FOR NURSES

Exceptionally competent nursing practice is not only more complex than I imagined, it is also more difficult to capture and communicate than I first supposed. However, I did gain some important insights about exceptional nurses and some unexpected supplementary insights were revealed circuitously. Included in the following sections are the insights arising from the study that may have significance for nurse administrators, researchers, educators, and clinicians.

Exceptionally Competent Nursing Practice: More than Competent Performance of Nursing Procedures

It appears that exceptionally competent nursing practice is more than competent performance of nursing procedures, although these exceptional nurses were skilled practitioners as well. Though the exceptional nurses studied performed the same nursing procedures as other nurses, their care seemed superior. They changed dressings, administered medications, bathed and positioned patients, assessed vital signs, and served meals as most nurses do, yet the positive effects on them and on their patients were notable. What was it that made their performance of these procedures different?

I suggest that part of the difference between competent and exceptional competence results from the beliefs and values that underlay the nurses' actions. As Wiedenbach (1964) says, a nurse's philosophy regarding the significance of life and the worth of each individual determines the quality of nursing care given.

THE DIFFERENCE BETWEEN COMPETENT AND EXCEPTIONALLY COMPETENT

I bathe my patient with water.
You bathe your patient in warmth.

I feed my patient toast and porridge.
You feed your patient hope.

I deliver to my patients
medications that make them well.

You deliver to your patients,
elixirs that make them whole.

Significance of the insight. If exceptional nursing practice is more than the competent performance of nursing procedures, this suggests implications for nurses engaged in clinical practice. In self-evaluation of their work they need to be aware that being an exceptional practitioner goes beyond being able to perform every item on a skills checklist.

Going one step further, this means that administrators and educators who hold formal responsibility for personnel and student evaluation may need to re-think their approaches to evaluation and incorporate ways of valuing the less quantifiable aspects of nursing practice.

If exceptional practice is more than accomplishing technical nursing skills successfully, nursing administrators need to provide nurses with time to learn and to practice nursing in all of its dimensions. It may be that it takes longer to give nursing service in an exceptional manner. At present work-load measurement systems do not take this into account. If administrators value exceptional nursing care they may need to consider new methods of work-load evaluation that allow time and freedom to practice the nursing actions that make nursing service exceptional.

Questions for further investigation. The role that the nurses' philosophies of nursing practice play in their ability to be exceptional practitioners requires further study. If indeed one's philosophy does influence the quality of nursing service provided then educators need to consider this in planning pre-service and continuing education programs. Perhaps they can incorporate learning opportunities that assist nurses to develop and embrace personal nursing philosophies that are consistent with exceptional practice.

There are many unanswered questions about how the actions that make nurses exceptional are acquired. Can nurses learn to use touch, silence, and light-heartedness or are these abilities a largely unalterable part of one's personality? How do you come to value honesty, genuineness, and ongoing personal and professional learning? If these skills, attitudes, and values can be taught, what are the most effective methods for doing so? Does it take more time to provide exceptional nursing service and to prepare one to give such service?

More research describing the less tangible aspects of excellent nursing practice is also needed to provide a more complete understanding. For example, a similar study could be undertaken with a focus on those exceptionally competent nurses who specialize in other clinical areas such as pediatrics, neurology, obstetrics, or renal dialysis, to determine whether the findings would be consistent with those reported in this study. Further research on exceptionally competent practitioners in other cancer centers could assist in the development of a general model of exceptionally competent oncology nursing practice.

Philosophy: A Blueprint for Action

The nurses' beliefs were like a blue-print for action. Their philosophies of nursing practice gave them direction, and because they held firmly to their beliefs, their philosophies gave them strength to go against the system and act as advocates for their patients when necessary. Again, it seems that the nurses' clear philosophies of nursing practice may have been at least partly the source of the exceptional nature of the care they provided.

Marie's story about her patient Ralph from Chapter 9 plainly illustrates an association between a nurse's strength of belief and her ability to act as an effective patient ally.

> He was only nineteen years old, far, far away from home and desperately in need of a bone marrow transplant. His home was in a small Native community in Northern Canada. He was Native, and this was his first trip outside the area in which he lived. Naturally, I expected that my task would be to support him and prepare him for his trip to Toronto for his transplant.

> But the more time I spent with Ralph, the more I realized he did not share those plans and hopes. Ralph always amazed me because he was insightful, spiritual, and truly at peace with his situation. He was also very alone, frightened and intimidated by the hospital surroundings. A bone marrow transplant would mean more loneliness and a greater separation from his family and home. A transplant at this stage of his lengthy illness provided only limited hope for a prolongation of life.
>
> Ralph confided in me that his only desire was to return home to be with his family, to experience a familiar sunset before he died. I knew in my heart this could be the only choice for him...Ralph was an inspiration to me. His decision was not popular with his physician who was disturbed by his "giving up," but Ralph never gave up on his decision.
>
> I, along with my colleagues, were resolved that going home was the only correct plan for Ralph. We presented Ralph's position to the doctors, and defended it adamantly. The bone marrow transplant was cancelled.
>
> Ralph never did return home, but died in room 72 surrounded by his mother, brothers, and sisters. He was at peace, and so was I. I truly missed his for sometime after. The medical goals of cure and treatment may often be less important when we can clearly distinguish between quality and quantity of life.

The nurses studied were able to articulate their philosophies of nursing including their views about the nature of human-beings and the nurse-patient relationship. They communicated these through their actions and their words. Clearly, they believed in the value of life, they respected individuality, and all their decisions and actions were directed toward the good of the patient.

More importantly, their patients were their reasons for being nurses. As these nurses considered each nursing action or interaction they thought about how it would affect the quality of life for that particular patient as that patient defined quality. The belief that the patient is the primary consideration seemed to sustain them in their practice. This stance made it easier for the nurses to make decisions and helped them be more confident in upholding those choices.

The nurses would often ask themselves, or their colleagues, "Is this action in this patient's best interest?" before proceeding with an intervention. For example, a patient being cared for by a nurse I was observing seemed close to death. The patient had been prescribed a laxative pill. This nurse was about to administer the drug when she said to me, "I've decided to withhold the medication. I don't want her last memories to be struggling to swallow this."

There were many examples of the exceptional nurses consciously weighing the patient's needs against the directives of the system. For the nurses their choices became straightforward when their philosophies of nursing were clear.

Yet, the beliefs held by these nurses were not necessarily static. The core ones perhaps were, but generally the nurses' philosophies were being refined over time through their experiences. At any moment the nurses knew what they believed about each aspect of their practice, yet they were open to changing their beliefs as they encountered new experiences.

MAKING CHOICES

When you know
what you believe,
choices are no longer
agonizing decisions,
they are readily prescribed
by your beliefs.

Significance of the insight. If a clear philosophy of nursing facilitates exceptional nursing practice, then nursing curricula should include case studies, simulations, and related experiences, and leadership opportunities that enable the exploration and development of a nursing philosophy by each novice nurse. Evaluations of nurses need to include qualitative components and discussion of the evolution of the nurse's belief system. Again, perhaps current approaches to nursing education and evaluation need to be rethought. This insight has implications for both nursing educators and administrators.

Questions for further investigation. It was interesting that the eight nurses studied shared very similar philosophies on matters of nursing practice. A question that requires further study is, why were their beliefs so similar? Several explanations come to mind and merit further investigation. For example, were these nurses socialized or acculturated in the work-place to develop common beliefs, or did they come to oncology nursing because of preexisting beliefs and values? Perhaps the stress of cancer nursing caused them to adopt specific beliefs as coping mechanisms? These, and similar questions would serve as beginning points for further investigations.

The Importance of Self-Awareness

There are some insights in this study regarding self-awareness, both the role it plays in being or becoming an exceptional practitioner, and how it is developed. It appears the nurses learned most about themselves from others, including colleagues and patients. These people were a mirror in which they recognized themselves. Through their interactions with others they identified their own limitations, that no one including themselves is perfect, and that interdependence leads to the greatest potential for success. In these ways they discovered both their own uniquenesses and their essential sameness.

In the oncology environment, and possibly in other stressful, urgent contexts, there is potential for developing high levels of self-awareness. Self-awareness was achieved, at least in part, when the nurses turned inward and faced their own existential questions. The oncology environment may be a catalyst for such introspection.

It appears that because the exceptional nurses knew themselves they were prepared to confront the issue of their own mortality, to understand the meaning of death, theirs and others. For them being prepared to die was to understand what it would mean to cease to exist as the selves they are. The nurse who understands this may be better prepared to give exceptional care to seriously ill people. Introspection and experience seemed to be ways by which the nurses developed this self-awareness.

The exceptionally competent nurses studied understood why they were nurses. They believed that they had chosen to be nurses, and they deliberately and regularly reconfirmed this choice. They also chose to enjoy their work and to learn from it.

The nurses' actions and behaviors stemmed in part from an intense knowledge of self and acceptance of self. Part of this self-awareness was knowing what they believed about nursing and about patients, but it also included knowledge of their own physical, emotional, and spiritual selves, and an awareness and acknowledgement of their own limitations.

ON DEVELOPING SELF-AWARENESS

Mirror mirror in my friend,
tell me where this all will end?
What a marvelous mystery,
look at you, it's me I see!

Significance of the insight. This insight has implications for nursing practitioners, administrators, and educators. If, as the findings suggest, self-awareness is critical to becoming an exceptional practitioner, then administrators and educators may want to explore ways in which nurses with whom they work can achieve this goal. Perhaps discussion groups in which nurses exchange examples of their practice experiences could be one way that this self-awareness might be facilitated. Preceptorship programs that pair novice nurses with those who have developed greater self-awareness may provide opportunities for development of additional knowledge of self in both parties. In addition, practicing nurses who become aware of the importance of self-awareness may independently seek opportunities for increasing their own self-awareness as part of their professional and personal development.

Thinking more broadly, perhaps self-awareness is a crucial part of being a successful practitioner in a variety of human services disciplines. If this is so, then again administrators and educators in these areas may wish to provide opportunities for their employees to become more self-aware.

Questions for further investigation. If self-awareness is important for excellence in nursing practice and the practice of other human services, then it is critical that the relative effectiveness of different methods for developing it be explored. Basically, how is understanding of self achieved? What roles do experience and introspection play in the development of awareness and understanding of self? Research seems needed on whether or not aspects of certain environments, such as stress level, enhance the development of awareness and understanding of self. Even more elementary, what is the self? Is it created? How do we become aware of our self? Research in these last-mentioned areas may also prove to be beneficial.

The Significance of Experiences with Death

Many of the nurses' stories and my observations were about death, either the moment of death or the nurse's relationship with the dying patient and the patient's family. Although death is not a frequent topic of conversation and debate in society, these exceptionally competent nurses had thought about death and viewed helping a patient to a peaceful, dignified death as an important aspect in providing appropriate and successful nursing care. Though working with dying patients was described by the nurses as difficult, they did not seem to find this part of their job abhorrent; rather, they found it rewarding.

The nurses studied articulated and demonstrated comfort with the topic of death and dying, yet their experiences with it seemed to make a profound impact on them. From encounters with the dying the nurses learned lessons that changed the way they provided care to others. These challenging situations changed them both professionally and personally.

LESSONS LEARNED FROM FACING DEATH

The walk
down the hallway to the dying patient's room -
it seems so long.

The doors
to the dying patient's room -
so difficult to open.

But anyone
who has the strength
to take the walk,

who has the courage
to open those doors,

may discover an extraordinary opportunity
to learn about the things of life
that really matter.

Significance of the insight. This insight has potential implications for those whose role it is to support clinical nurses and facilitate their professional development, primarily nurse educators and administrators. If these individuals are aware that caring for dying people may have a powerful effect on clinical nurses, measures can be taken to assist them to participate meaningfully in such situations. Such encounters with death may provide prime "teachable moments."

The intensity of situations involving patient death is well documented in this study. It should be important information for nurse administrators: nurses who face the death of their patients in their work may require additional opportunities and time to reflect on these experiences. Perhaps time allotted for debriefing after such events may result in direct benefits for the nurses involved. In addition, indirect benefits for the health care system may result if the nurses, as a result of learning from these experiences, are then able to provide more meaningful care to other patients.

For nurse educators who teach pre-service programs, this insight suggests that a component of the curriculum should specifically address patient death and the issues that surround it. The nurses' stories of their experiences with death would be useful resources in such classes.

Questions for further investigation. Several interesting research possibilities arise from this insight. For example, why are oncology nurses' experiences with death so important to their personal and professional development? What methods of support do nurses find most helpful when confronting death? Are the support needs of competent nurses different from the needs of exceptionally competent nurses? How do nurses develop the understanding that death is an appropriate nursing goal in certain situations? What part do work-experience, life-experience, and introspection have in helping nurses recognize that they can play a major role in making a patient's death a pinnacle moment for everyone involved?

The potential for research arising from this insight is enormous. Studies that address these and similar questions could have implications as well for other health care providers.

Moments of Growth: Teaching Others, Making a Difference, Caring for People Who Are Like You

Beyond their encounters with the dying, it appears that many of the significant practice moments reported by the nurses studied involved patients who shared similar circumstances with the nurse such as age, gender, or being parents to young children. The nurses wrote, at least in part, about how these experiences related to their own lives. Other memorable, critical nursing moments revolved around times when the nurses made a difference in someone else's life, when they learned something that changed their practice or their view of the world, and when they had an opportunity to share their knowledge with a colleague. During these significant practice moments when they taught others, the nurses also reported learning themselves.

As discussed throughout the dissertation, the exceptionally competent nurses were challenge seekers. It seems that many of these moments of growth came when they faced some of their greatest challenges.

MOMENTS OF GROWTH

There you are -
female, 32, a mother.

Here I stand -
female, 32, a mother.

By the nature of our similarities,
the borders of our realities blend.

When you hurt,
so do I.

When you cry,
so do I.

When you die,
so does a part of me.

Significance of the insight. This insight could have implications for nurse educators. If nurses learn most when they are teaching others, and when they are caring for patients who share similar life circumstances to their own, then educators could use the learning potential found in such situations. Providing nurses with such challenges may be a way of presenting them with growth opportunities.

This is not to say that nurses should only be matched with patients who are similar to them. To be exceptional nurses need to be able to provide exemplary care to people from any age group, race, sex, ethnicity, or marital status. As demonstrated in the findings chapters, the exceptionally competent nurses studied were able to do so. However, this insight is meant to demonstrate that in situations where there are similarities between the patient and nurse enhanced opportunities for learning may arise.

In their efforts to provide support to clinical nurses, nurse administrators may benefit from being able to anticipate which patient situations the nurses might find most significant. If administrators could anticipate that certain situations might be critical for the nurses they would be prepared to arrange appropriate interventions such as counselling or team support discussions.

Nurse clinicians may discover this insight is beneficial to them as they work toward enhanced self-awareness. They may find it guides them as they search for growth opportunities.

Questions for further investigation. There is an apparent need for further research to facilitate understanding of how nurses are affected by their patients' circumstances. Why do incidents of this nature have such a profound effect on nurses? In these situations are the nurses needs for affirmation of value and ongoing personal and professional growth met? Further understanding of questions such as these might be helpful to educators, administrators, and clinical nurses.

Touch, Silence, and Light-Heartedness: Modes of Communication, Means of Connecting, Affirming Value and Transcendence

THE IMPRINT

Your touch.
A gentle brush across my cheek.
How can something so faint,
so soft,
so subtle,
leave such an indelible imprint
on our souls?

THE GIFTS OF SILENCE

With my silence I give you everything,
permission to cry,
to laugh,
to be silent too.

SOCIAL CLIMATE CHANGE

Laughing together
makes the social climate,
summer or winter,
ideal.

The nursing actions of sharing the lighter side of life, participating in a dialogue of silence, and employing mutual touch are all means by which the exceptional nurses communicated with their patients. Sometimes nurses used these methods of communication while they were performing technical nursing interventions. On other occasions these communications were the sole nursing activity of a nurse-patient encounter. By these means the nurses let their patients know of their concern and respect for them. In a way, through these actions, the nurses communicated their beliefs to their patients.

A characteristic of these three communication modes is that they are all shared experiences, reciprocal in that both people usually need to be involved. Shared communication may be the means by which nurse-patient relationships are transformed into person-to-person relationships. Watson (1989) describes "human-to-human connectedness" and "transpersonal caring" and I believe that touch, silence, and light-heartedness may be ways by which these are achieved.

According to Watson (1989) in such circumstances "each is touched by the human center of the other" (p. 131). I suggest that when these moments occur there is an inter-human connection that leads to affirmation of value and transcendence of both the nurse and the patient. These moments are as O'Banion and O'Connell (1970) describe, "Human encounters that have a diamond-like quality of brilliance and value and the potential to make one feel uplifted, completely understood, and transformed in some way" (p. 7).

PERSON TO PERSON

In the beginning,
when I was a new nurse
standing in front of you
with trembling knees and
gleaming shoes and
text-book approaches,
I called you my patient.

Now,
I stand beside you,
I touch you,

I laugh with you,
I stay with you through silence,
and I call you by your name.

Our relationship is no longer
nurse to patient,
it is now
person to person.

Significance of this insight. This insight provides an example of some actions exceptionally competent nurses use in their practice. Those nurses who use similar approaches in their care may feel reassured that other excellent nurses share their methods. Nurses who are seeking to enhance the care they provide may decide to incorporate touch, silence, and a light-hearted attitude into their practice.

Nurse educators, both those in pre-service and continuing education, may seek ways to include experiences that facilitate the development of these approaches in the practice of the nurses they teach. Nursing administrators who value exceptional nursing care need to provide resources and opportunities for nurses so that these actions can be incorporated into daily nursing care.

Questions for further investigation. There is still much to discover about these concepts: silence, touch, light-heartedness, affirmation of value, connection, and transcendence. What is needed are more complete descriptions of these actions and interactions and a greater understanding of how they affect both the patient and the nurse. These concepts cannot be measured and quantified, so the best way to learn more about them may be to continue to observe, converse with, and solicit stories from those closest to the patients, their clinical nurses.

The effect that sharing silence, touch, and lightheartedness have on nurses would be especially interesting for educators. This project did not specifically address the question of how these nurses became exceptionally competent. Perhaps the nurses became more self-aware in some measure through their experiences. As they gradually reveal themselves to their patients, they also begin to have a better understanding of themselves. I imagine that through these encounters the nurses gradually take off masks and costumes, including armor, that have kept them from understanding their own practice. True genuineness evolves. O'Banion and O'Connell (1970) claim that when "We become less hidden, we realize that we are capable of reaching toward each other across our physical separateness" (p. 44).

Motivation and Satisfaction of Exceptionally Competent Nurses: A Miracle Circle

This research taught us something about how these exceptionally competent nurses are motivated to continue to give excellent care. It seems nursing is a positive and rewarding experience for these nurses. They expressed a high regard for their work. The intrinsic rewards they identified included feeling valued, and the opportunity for continued professional learning and personal growth, both of which they desired.

Many of the examples indicated that involvement in patient-nurse interactions within this context satisfied some of the nurses' priority needs. It seems that their actions in cyclic fashion initiated self-fulfilling reactions. As the exceptionally competent nurses met the patients' needs in an exceptional way, they had their own needs fulfilled. Having been fulfilled themselves, the nurses were able, and perhaps even motivated, to continue to provide exceptional care to meet their patients' needs. In this way nurses were both motivated by and found satisfaction in their work. The consequences became the basis for further exceptional care.

THE MIRACLE CIRCLE CONTINUED

My small gesture,
lovingly given,
causes you to feel valued.

When you feel important,
so do I.

Satisfied that I do make a difference,
I am motivated to
continue to care for you and for others.

Significance of this insight. There are many unanswered questions about the motivation and satisfaction of nurses. It would be helpful to administrators and educators to have knowledge of some of these. Educators in particular would want to know how these nurses entered into and stayed in this positive cycle so they could help other nurses do the same. Administrators concerned with both employee motivation and job satisfaction would want to provide an environment that allows such intrinsic reward patterns to be initiated and to continue. For clinical nurses seeking to avoid "burnout," further understanding of this positive cycle could be very helpful.

Questions for further investigation. This service-motivation cycle appears to be very positive and mutually beneficial for both the nurse and patient, but further research might focus on how such a cycle is initiated? Why is nursing so satisfying to these nurses, while other nurses find nursing too stressful and suffer symptoms of burnout? Could it be that there is a match between the personal needs of these nurses and the expectations of the job, in this case nursing? Is it important that the nurses appreciate the intrinsic rewards provided by exceptional nursing, affirmation of value and opportunity for continued professional learning and personal growth? Is this cycle ever broken, and if it is what causes the change and can the mutually beneficial relationship be regained? What role does organizational context play in helping nurses to be exceptional care-givers? What role does personality of the nurse play?

Even more basically, what is the source of the motivation that causes nurses to reach out and give to patients initially? Is it as some suggest a human instinct to be compassionate and to care? Maybe some of the motivations for continuing to be exceptional practitioners are the consequences of professional and personal growth and satisfaction that they make a difference in the lives of their patients, but what is the initial catalyst?

Specific to the patients, do they find care given by exceptionally competent nurses to be exceptional? Is this cycle as beneficial for the patients as it seems to be for the nurses? Do the patients experience what I have recorded as exceptional care as desirable? There is a need to record the patients' perspective on this phenomenon. It is possible that what the patients desire in their care-givers are different qualities and approaches than nurses admire in their colleagues.

Likely it is a very complex situation. There are possibly multiple individual reasons for the nurses becoming engaged in providing nursing care initially, and staying engaged for the longer term, but it would be a revealing area of study.

Confronting Cancer: A Shared Experience

One of the incidental discoveries from this research was a glimpse at the nature of cancer. This study provides an enhanced understanding of what it is like to confront this disease as a patient, a family member, and most clearly as a nurse.

The stories reveal that cancer can involve intense human suffering and "chronic sorrow" (Eakes, 1993). This disease shows no favoritism; it has the potential to affect anyone at any age or stage of life; no one it seems is immune.

Those affected by cancer and those around them are forced to confront their mortality. Part of the oncology experience seems to be grieving for oneself as well as for others. Confronting cancer causes people to lose their illusion of immortality, to recognize their vulnerability, and their lack of control over their health.

Providing care to those with many types of cancer is like fighting a war against death, disfigurement, and psychological and spiritual collapse, yours and the patient's. The nurses studied showed us that to be effective in this contest nursing care must be complex, individualized, and delivered in a highly competent manner. The nurses fight for themselves and their own integrity as they fight for their patients. It is a shared experience.

From the stories we can sense that the oncology milieu is one of intensity and urgency. At any moment any one of the players could lose control, so there is a constant checking to see if they are still all within the threshold of normalcy.

Perhaps this ever-present sense of urgency combined with the emotions that are part of each encounter to a greater or lesser extent, affected the nursing care given by the nurses studied. Such an environment reduces the "noise" in relationships and short-cuts are taken to establish inter-human connections quickly.

The oncology environment has the potential to be very stressful. Oncology nurses ride the waves of emotion with their patients. At any given moment a nurse may be simultaneously experiencing the high of a disease in remission with one patient and the low of disease metastasized with another. It takes a very strong, self-aware person to be pulled and tugged in so many ways and to be able to withstand what would otherwise cause emotional and physical strain. Yet, if the nurses are able to stay with the struggle, like the exceptional ones have, they are forged like steel by the forces of emotions and the energy of experience. Rather than becoming hard and immovable, the nurses become stronger, preserved, able more easily to withstand the forces in their environment. As Martin Luther King said, "What doesn't destroy me makes me stronger."

IT'S NOT EASY BEING AN ONCOLOGY NURSE

Every day you fight a battle against
physical, emotional, and spiritual collapse,
yours and your patients.

Each day is infused with an intensity,
a sense of urgency.
Waves of emotion wash over you
as you move from situation to situation.

At first you are never sure if
the next experience might be the big one,
the one that overwhelms you.

Eventually you find that from each
encounter you emerge stronger,
more sure of your abilities,
confident enough to carry on for the next day,
and probably the day after that.

Significance of the insight. A greater understanding of the environment in which oncology nurses work has significance for administrators in these contexts. In addition, those responsible for continuing education programs in cancer centers, clinical nurses who specialize in oncology, and those considering a career in this speciality can all benefit from this insight. This knowledge could be helpful in preparing people to provide nursing care to cancer patients and in establishing support programs for oncology nurses.

Questions for further investigation. A question arising from this insight concerns how nurses cope with the dissonance of simultaneously caring for patients who hope for a cure for their disease and others who are dying? The nurses studied seemed to thrive and grow as a result of their work. How do these nurses keep from being destroyed while others are not able to withstand the stress and leave the oncology specialization or nursing completely? What is it within the environment that these successful nurses find supportive? Nurse administrators and educators would find answers to these questions helpful.

GENERAL INSIGHTS OF POTENTIAL SIGNIFICANCE FOR HUMAN SERVICE PROVIDERS

Some over-arching insights emerged from this research that may have significance for people who work in human services fields besides nursing. These insights are described below.

Change: An Opportunity for Transcendence

Our lives are constantly changing. With each change come associated challenges that are opportunities for transcendence of self and others. For example, our level of wellness is not static and with transitions in our states of well-being new challenges are presented to self, family, and care-givers.

These challenges and changes in life and wellness, to self and others, are opportunities for transcendence. Perhaps the more serious the challenge or threat to life and health, the greater the possibilities for growth.

ON THE CHANGES IN LIFE

Change,
a part of your life and mine.

Embrace it.
Use it.
Grow through it.

Touch: More Than Physical Contact

Nurses and some other human service care-givers by the nature of the technical tasks prescribed by their roles have implicit permission to physically touch their clients. Other human services personnel do not have this advantage and may even be discouraged from physical contact with their clients fearing misinterpretation of such gestures.

However, interpreting this research broadly it seems that touch is more than physical contact between individuals. People can touch one another physically, but spiritual, emotional, and intellectual touch are also possibilities. Each vocation may find one or more of these types of touch most appropriate to their work. For example, chaplains may communicate through spiritual alignment, psychologists through emotional contact, and teachers may touch their students intellectually through the sharing of information and cognitive challenges. People in human services fields can take advantage of the communication opportunities provided by alternative approaches to touch, letting their clients know of their concern and respect for them.

INTERPLAY OF THE MINDS

When you share your
ideas and understandings with me,
it tells me that I
am important enough to
be trusted with something that is a part of you.

The Complexity of Human Interactions

Another broad understanding supported by this study is that human interaction is complex and sophisticated, different types of interaction, for example verbal and non-verbal, usually occur simultaneously. People act as they react, and react as they act. The inter-personal process appears to be incessant, fluid, and non-linear.

Some of the most important elements in human interactions are the seemingly unheard and invisible. Although we do communicate through the well-recognized ways such as speech and gestures, we also communicate by laughing with others, touching them, and sharing silence with them.

If you touch someone, remain present with them even in silence, and share with them in light-heartedness, you promote a sense of worth in the other. In the larger view this sense of self-worth in individuals may create a sense of worth in the community and in turn in society.

ON HUMAN INTERACTIONS

On closer inspection,
our interactions with others
are not as orderly
as I once thought.

Transcendence: A Shared Process

Another important discovery concerns an increased understanding of transcendence. It seems to be a life-long process. We are continually refined by our experiences, especially our interactions with others, with self, and perhaps with a higher entity. Being open to the promise that relationships offer may help us transcend to the highest level of human potential. We cannot transcend alone. To reach this premier state of being we must be as open to receiving from others as we are open to giving to them.

ON THE SHARED JOURNEY

We cannot transcend alone;
it is a shared journey.

As we transcend through our
experiences with others,
we open up the opportunity
for them to come along.

An Extended View of Beauty

What is beauty? This research helped me recognize that our dictionary and societal definitions of beauty are very limited. In the field I saw beauty in many things that are not recognized generally as beautiful. As O'Banion and O'Connell (1970) say, "What is more beautiful than a man weeping, [or]...the eyes of someone welcoming death?"

This extended view of beauty was important for the nurses providing care. Once they redefined beauty they saw the core of their patients, past what society labels as repulsive and unattractive. For similar reasons others who work with people can benefit from an appreciation of beauty in more than its physical elements. The following story written by Jane illustrates this redefinition of beauty.

> I think the patient I will always remember is a woman named Heather. She was young, only 34, and she had flawless olive skin and waist length, thick, black hair. Heather was one of the most physically beautiful people I had ever cared for. Her recent diagnosis meant that her chemotherapy treatments had only just begun. I was the nurse responsible for administering her chemo. She was being treated with a combination of drugs known to cause hair loss.
>
> Heather had just been hospitalized for her second course of chemotherapy. When I asked her how she had been since her last treatment she talked about some nausea and mentioned that her hair was starting to fall out. She was noticing many strands on her pillow every morning. As the days went by the hair loss became greater until it got so that she could pull her hair out by handfuls.
>
> The night I remember she rang her bell and asked if I could help remove the remainder of her hair. I did. We sat together on her bed with a green garbage bag between us stuffing it full of her beautiful hair. I was speechless. In fact, I couldn't believe what was happening. I felt so guilty having hair and being well.
>
> When we were finished we tied the bag closed. I looked right into her eyes, took both her hands and said, "Heather, I think you are still beautiful." I cried and she comforted me. We hugged for awhile and I took the bag and walked away.

ON DEFINING BEAUTY

You are a goddess,
a beauty in body and spirit.
No matter how this disease ravishes you,
a beauty you will always be.

The temporary
and transient beauty
of your face,
your hair,
your body,
pale against the permanent beauty
of your soul.

The Challenges of Researching Human Experience

There are many research methods questions that continue to challenge me even as this study nears completion. I wonder how much I have affected the findings of this research? Just how real is what I have recorded and put forward as the findings of my study? Is this largely a filtered view of other nurses' experiences?

I wonder how different this dissertation would be if someone else reading the same stories, hearing the same comments, and watching the same interactions had written it? Or what if I wrote it a year from now? How much do my narratives and the nurses' stories capture what really happened? What if I had read just a few more articles or stayed in the field just a few more days, how different would this report be?

I believe that these questions are important. Although they are not easily answered, they do bring to consciousness some of the difficulties associated with doing research on human experience. Others attempting similar projects will come to realize that their interpretation represents one of many possible understandings of their area of investigation and that given the complexities related to research involving human experience such projects can likely never be complete or capture every intricacy precisely.

The Potential of Narrative Exchange as a Research Method

During this study I did learn that stories and narrative exchange are powerful research methods, partly because they are a natural means of communication. For me they were important sources of understanding. An interview, no matter how unstructured, by its very nature imposes some limits on what is said and how it is expressed. Stories are liberating, they liberate the tellers so they can share what is important to them and so they can analyze their experiences as they go along. Stories are rich with details about how the experience affected the story teller. The following story written by Marie illustrates this well.

> Linda was just 19 years old and she had already lost her arm and shoulder to cancer. I was always amazed at how joyful and positive she was and I thought this can't be for real. But it was. I learned Linda had lots of support at home. She was really close to her sister, and she had a strong religious conviction. I cared for her often over a period of about two years. When ever we would have new patients with the same diagnosis as Linda, and she was around, she would offer to come and help me teach them about their disease. Using herself as a model, she would just whip off her shirt and show them her scars.
>
> Toward the end Linda met me in the hall and told me that her disease had spread and the doctors wanted her to try

> radiation treatments. I encouraged her to take the therapy, it was all I could do, she was only 19.
>
> But for her taking the radiation was wrong and she let me know that it was. I was stunned. I just kept shaking my head and saying in disbelief, "You are not going to try?" I felt upset because she wasn't fighting it. The nurse in me wanted to do something for her. I didn't want to lose her. It would have been easier for me to be more palliative with her if she had been in my age group, but she was only a teen-ager.
>
> When she saw I was falling apart, Linda took me aside, put her arm around me and said, "No Marie, it has just spread too much. I can't do this any longer. I'm O.K. I know I'm going to die, and I am O.K. with that." I was shattered.
>
> A few weeks later we had a call from the nurses in Linda's community. It's a couple of hours drive from here. They wanted to learn how to look after her at home so she could be with her family until the end. I asked to be the one to go to the community and teach the nurses what they needed to know. Though I was eight months pregnant with my first child, I wanted to be the one to do something for her.
>
> About 15 minutes into the teaching session with the nurses, Linda showed up. She wasn't well. She was thin and pale, but she looked at me and said, "Here I am Marie, I wanted to come today and be your model like I've always been."
>
> Then the class was over and she had to go. I wasn't coping very well with the good-bye because I knew it would be our last. Again she nurtured me. I will never forget what she said...she said, "Marie, it's O.K., in fact, it's kind of exciting. Here you are going off on a new journey of motherhood and I'm off on a journey of my own. We are both going to be just fine."
>
> I was so preoccupied driving home. It was true. I was off to become a mom and she was off to...I didn't know for sure to where, or to what; but she did.

As well, telling stories may have a cathartic effect and it can be a further method of increasing self-awareness of the teller. It appears that narrative exchange helps the teller as well as the researcher understand an experience. This is clearly illustrated in Julie's comments:

> I just want to say thanks for helping me open up a part of me I could have shared in no other way but by writing my stories. There was something so liberating about sitting down with a blank page.

Significance of this insight. This insight has implications for human services researchers as they choose methods they will use in conducting similar investigations. Perhaps this study provides added support for the use of narrative methods in comparable studies of human action, interaction, and thought. In addition, as addressed in Chapter 1, administrators and educators having been made aware of the potential positive effects of narrative writing and exchange may choose to employ this technique in teaching and leadership.

Questions for further investigation. Research related to the effect on the writer of a story could be enlightening. How do the nurses who wrote stories for this research feel about this medium of expression? Did being asked to share their experiences have an empowering effect on them? Although some nurses did comment on this question, further specific exploration of the effects upon them could be revealing.

SUMMARY STATEMENT

In summary, I contend that this study has increased our understanding of the nature of exceptionally competent oncology nursing practice, specifically the beliefs, actions and interactions, and effects of the actions and interactions involving these nurses.

Essentially, exceptional nursing practice is more than being technically competent. It is being self-aware and communicating with patients person-to-person through touch, silence, and sharing the lighter-side of life. These actions involve nurses sharing part of themselves with the patients, and allowing the patients to share themselves with the nurses.

Exceptional nurses have well developed nursing philosophies that become their blueprints for action. Important elements of these philosophies include a reverence for life and respect for the value of each individual. These nurses have become self-aware and have developed their philosophies at least partly through interaction with patients with whom they have identified closely, through teaching others, and through experiences with death.

Exceptionally competent nurses seem to be both motivated by their work and draw satisfaction from it, especially by the opportunity to feel valued for what they do, and by the chance for personal and professional growth. Exceptional nursing practice includes sharing the cancer experience with the patients, struggling and growing with them, and using these unfortunate circumstances as an opportunity for both the nurse and patient to achieve transcendence.

In addition, I believe this study has shown the power and promise embedded in nursing care, exposing the often hidden, yet invaluable contribution made by clinical nurses. The nurses' stories illustrate the challenge of living with cancer and of caring for people with this disease.

Of interest to researchers, this project has demonstrated a fruitful approach for collecting, recording, and reporting research findings. This technique of coupling credible qualitative methods could be of use to researchers in many human services fields.

For the profession of nursing, this study has contributed to the growing body of knowledge that the profession can consider its own. Some of the essential features of exceptional nursing practice have been explored and described.

Finally, there are many more insights that could be drawn from these data. Probably the most important discoveries will be made by practicing clinicians who may examine this study in the context of their own practice.

LESSONS LEARNED:
ON BEING AND BECOMING EXCEPTIONAL

Touch others,
physically, emotionally, intellectually, and spiritually.

Learn to use silence,
it provides a powerful means of communication.

Approach life light-heartedly,
lightness can be shared even in the darkest seasons.

Focus on the potential,

yours and others.

Embrace change,
it is an opportunity for transcendence.

Find work that you enjoy,
that makes you feel valued and challenged.

Study people carefully,
in doing so you will learn much about yourself.

Determine what you know,
and seek chances to teach it to others.

Discover what you believe,
and live it with confidence.

Appreciate others,
and pursue opportunities to contribute to their happiness.

Realize that you are not perfect,
and accept that you probably will never be.

Know your strengths,
and blend these with the strengths of those you meet.

See beauty,
for it is all around in forms not instantly recognizable.

Be as open to receiving as you are to giving,
this is a gift to others as well as to yourself.

Seek challenges,
and enjoy the privilege of learning from them.

Tell your stories,
for they are you.

Share your journey,
you cannot sparkle alone.

EVOLUTION OF THE RESEARCHER

Undertaking this study has changed me. I have confronted and dealt with ghosts of my past. No longer frightened by what lies ahead, I am prepared to meet each moment as it comes. A feeling of hope replaces what was once dread; a feeling of worth replaces what was once insignificance. I realize more assuredly how complex human experience is, and how important people are to one another. I began thinking I was doing this project for someone else. Now, I realize that, though I did do it for others, I also did it for me.

Then the day came
when the risk to remain
tight in a bud
was more painful
than the risk it took
to blossom.
(Anais Nin)

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APPENDIX A

LETTER INVITING PARTICIPATION IN THE STUDY

March 16, 1992

Dear _____________:

My name is Beth Perry and I am currently on educational leave from the Cross Cancer Institute where I am the Coordinator: Professional Development. I am studying Educational Administration at the University of Alberta pursing a Ph.D.

I am interested in learning more about "unusually competent" registered nurses who care for patients with cancer. The registered nurses on your unit have been selected as the group from which unusually competent nurses will be identified to be studied. Approval has been received from your hospital's research steering committee to proceed with this research project. I hope that through a combination of interviews and observations of nurses identified by their peers as unusually competent an increased understanding of how this competence is attained, used, and maintained will result.

The initial step in this research process is the identification of those nurses on your unit who are considered by their peers to be unusually competent.

I need your help to establish this list of unusually competent nurses. Please print in the space below the full names of the nurses who work with you whom you consider to be unusually competent. These are the nurses you would want to have care for you or a family member who becomes ill with cancer.

Include your own name if you consider yourself to be a unusually competent. Please consider full-time and part-time registered nurses. It is important that you complete your list independently without consulting your colleagues.

Once your list is complete please seal it in the envelop provided and return it to ___________. She will forward all replies to me unopened.

I will be compiling a summary list of all of the nurses nominated. From this list, a minimum of six names will be randomly selected as study participants. These nurses will be approached and invited to participate in the project. If any of the nurses selected decide not to participate or if additional study participants are needed for any reason, these nurses will be randomly selected from the master list of usually competent nurses. At no time will a nurse know if she or he was nominated unless his or her name is randomly selected as a participant. The master list of unusually competent nurses will only be known to the researcher.

If you have any questions about this study or the nomination process I will be available in your consultation room March 18th from 1130 to 1330 hours and March 26 from 1400 to 1630 hours to answer your questions. Alternately, I can be reached at 438-3442 any time. I would appreciate receiving your list of nominees before March 31, 1992.

Thank-you for your assistance. I hope this research project will lead the way towards increased understanding of how optimal levels of achievement for oncology nurses can be facilitated.

Beth Perry R.N.

APPENDIX B

CONSENT FORM FOR PARTICIPATION

A STUDY OF SELECTED UNUSUALLY COMPETENT ONCOLOGY NURSES

I acknowledge that this research project has been explained to me and that any pertinent questions I have asked have been answered to my satisfaction. I understand that Beth Perry at 438-3442 or __________ at _____________ will answer any additional questions that I have about the research project. I understand that participation in the study is completely voluntary and that I will receive no remuneration for the time spent working on this project outside of my normal work hours. Should I decide to participate, and later decide to withdraw from the study, I may do so at any time without jeopardizing my career in any way.

I understand that I will receive a copy of the information sheet and this signed consent form, and that this project may be reported, but I will not be identified. I have been assured that my confidentiality will be respected.

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Name of Participant (please print)	Signature of Participant
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Name of Witness (please print)	Signature of Witness
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Name of Investigator (please print)	Signature of Investigator

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Date

BETH ANNE PERRY

105 Street & 24 Avenue
Edmonton, Alberta
Canada T6J 4J7

(403) 438-3442

PERSONAL INFORMATION

Date of Birth: October 26, 1957

Interests: Writing, fitness, international cuisine, finance, travel, personal challenges

EDUCATION

1990-1994	Doctorate of Philosophy Educational Administration University of Alberta
1988-1990	Master's of Health Services Administration University of Alberta (Incomplete - Transferred to Ph.D.)
1978-1982	Bachelor of Science (Nursing) University of Alberta
1977-1978	Bachelor of Science (Biology) University of Alberta
1975-1977	University Transfer Program Grande Prairie Regional College

PROFESSIONAL EXPERIENCE

1994-Present (Part-time)	Sessional Instructor Educational Administration University of Alberta
1991-1994 (Part-time)	Instructor/Teaching Assistant Educational Administration University of Alberta
1988-1991	Coordinator: Professional Development and Nursing Research Cross Cancer Institute
1985-1988	Assistant Education Coordinator Cross Cancer Institute

1984-1985	Chemotherapy Nurse Cross Cancer Institute
1982-1984	Oncology Staff Nurse Cross Cancer Institute

AWARDS AND SCHOLARSHIPS

1991-1994	Social Sciences and Humanities Research Council of Canada Doctoral Fellowship
1991-1993	Walter H Johns Graduate Fellowships
1990	University of Alberta PhD Scholarship
1990	Maurice Legault Cancer Nursing Fellowship
1990	Yvonne Chapman Scholarship Alberta Association of Registered Nurses
1989-1990	Edna Minton Endowment Fund Cancer Nursing Scholarships
1989-1990	Canadian Cancer Society Nursing Scholarships
1982	McClure Gold Medal in Nursing University of Alberta
1980	Board of Governors Prize in Nursing University of Alberta
1977	Alberta Wheat Pool Scholarship
1976-1982	Province of Alberta Scholarships

PROFESSIONAL ACTIVITIES

1990-Present	Canadian Nurses Association (Member)
1989-1991	Provincial Council Representative Alberta Association of Registered Nurses
1985-Present	Canadian Oncology Nurses Association (Member)
1982-Present	Alberta Association of Registered Nurses (Member)

PUBLICATIONS AND TEACHING BROCHURES

Perry, B. (1994). Knoop's taxonomy: Balanced but limited. *Canadian School Executive*, 13(7), p. 34.

Perry, B. (1993). A comparison of decision-making models. *Canadian School Executive*, 12(3), p. 16-19.

Perry, B. (1989). Pain management update. *AARN Newsletter*, September.

Perry, B. (1989). Such a simple procedure - Such wonderful results. *AARN Newsletter*, July-August.

Perry, B. (1989). Could I have an order for_____? *AARN Newsletter*, June.

Perry, B., MacMillan, K., & Michaud, M. (1989). Is P.C.A. the answer? *AARN Newsletter*, March.

Perry, B., & MacMillan, K. (1989). *Your patient has an Edmonton injector*. Edmonton, AB: University of Alberta Printing.

Perry, B. (1988). Our experience with the Port-a-Cath system. *AARN Newsletter*, April.

Perry, B., & Brenneis, C. (1987). *You have a Pharmacia 5200 pump*. Edmonton, AB: University of Alberta Printing.

Perry, B., & Brenneis, C. (1987). *Your patient has a Pharmacia 5200 pump*. Edmonton, AB: University of Alberta Printing.

Bruera, E., Brenneis, C., Perry, B., & MacDonald, R. (1987). *Continuous subcutaneous administration of narcotics for the treatment of cancer pain*. Markham, ON: Knoll Pharmaceuticals Canada.

Perry, B, & Brenneis, C. (1986). *Your patient has a Travanol Infusor*. Edmonton, AB: Dial Printing.

Perry, B., & Brenneis, C. (1985). Pathological fractures. *ONIGA Newsletter*, March.

Perry, B., & Duclos, S. (1985). Brachytherapy to the brain. *ONIGA Newsletter*, January.

INVITED PRESENTATIONS

1994 Hearts and Hands of Exceptional Oncology Nurses
International Conference on Cancer Nursing
Vancouver, British Columbia

1993 Who are we as a Department of Educational Administration?
Graduate Student Orientation
University of Alberta
Edmonton, Alberta

1993 Unusually Competent Oncology Nurses
Grand Rounds Edmonton General Hospital
Edmonton, Alberta

1992 Unusually Competent Oncology Nurses
Interdisciplinary Palliative Care Conference
Edmonton, Alberta

1990 Pain Management in Post-Operative Patients
OR Nurses Conference
Edmonton, Alberta

1989 Innovation in Education
Canadian Association of Nurses in Oncology Conference
Halifax, Nova Scotia

1989 Subcutaneous Infusion Teaching Resources (Poster)
Canadian Association of Nurses in Oncology Conference
Halifax, Nova Scotia

1989 Canadian Distance Learning Development Center Interactive Teleconferencing (Poster)
Oncology Nurses Interest Group of Alberta Conference
Calgary, Alberta

1989 Administration of Chemotherapy (Teleconference)
Alberta Hospitals Association
Edmonton, Alberta

1989 Cancer Pain can be Controlled (Teleconference)
Alberta Hospitals Association
Edmonton, Alberta

1989 Chemotherapy Update
Nursing Rounds, Grande Prairie Cancer Clinic
Grande Prairie, Alberta

1989 Oncology Nurses Providers of Hope (Keynote)
Saskatchewan Oncology Nurses Group Conference
Saskatoon, Saskatchewan

1989 Cancer Care Workshop
Saskatchewan Oncology Nurses Group Conference
Saskatoon, Saskatchewan

1989 Innovations in Cancer Care
Meeting of the International Order of the Daughters of the Empire
Edmonton, Alberta

1989 Oncology Nursing: What's New?
Canadian Cancer Society Meeting
Vermillion, Alberta

1989 Nursing Care of the Cancer Patient (Workshop)
Canadian Distance Learning Development Center
Edmonton, Alberta

1988 Administration of Antineoplastics
Canadian Intravenous Nurses Association Conference
Kananaskis, Alberta

1988 Documentation in Outpatient and Inpatient Oncology Settings (Poster)
Canadian Association of Nurses in Oncology Conference
Vancouver, British Columbia

1988 Chemotherapy and Radiation Therapy
Faculty of Nursing, University of Alberta
Edmonton, Alberta

1987 Chemotherapy
Nursing Rounds, Royal Alexandra Hospital
Edmonton, Alberta

1987 Supportive Care in Cancer Therapy
Nursing Rounds, Charles Camsell Hospital
Edmonton, Alberta

1987 Exstravasation
Nursing Rounds, Royal Alexandra Hospital
Edmonton, Alberta

1987 An Overview of Oncology Nursing
Canadian Cancer Society Meeting
Valleyview, Alberta

1986 Chemotherapy Administration (Parts 1 & 2)
(Teleconferences)
Alberta Hospitals Association
Edmonton, Alberta

1986 Early Detection and Prevention of Female Cancers
Canadian Cancer Society
Ponoka, Alberta

1986 Early Detection and Prevention of Cancer
Cold Lake, Alberta

1985 The Realities of Patient Teaching
Faculty of Nursing, University of Alberta
Edmonton, Alberta

1985 An Overview of Leukemia & Colorectal Cancers
Faculty of Nursing, University of Alberta
Edmonton, Alberta

PROFESSIONAL ACCOMPLISHMENTS

1990 Chaired - Cancer Care: The Complete Circle Conference

1990 Developed and piloted an Oncology Nursing Certificate Program

1988 Established a Cancer Pain Management Program for nurses and pharmacists

1987 Wrote and directed videos for nurse and patient education

1987 Established an Oncology Nurse Residency Program

1986 Designed an Advanced Chemotherapy Administration Program

COMMUNITY ACTIVITIES

1985-1987 Volunteer
Canadian Cancer Society

REFERENCES

Available upon request